BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	No. **D1-1996-69949**
Lawrence Saks, M.D.	)	
Physician and Surgeon's Certificate No. G 36859	)	
	)	
Petitioner	)	

ORDER DENYING PETITION FOR RECONSIDERATION AND REQUEST FOR STAY

The Petition filed by John Mulvana, attorney for Lawrence Saks, M.D., for reconsideration and Stay of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on **December 22, 2008.**

IT IS SO ORDERED: December 22, 2008.

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: LAWRENCE SAKS, M.D., Physician's and Surgeon's Certificate Number G36859 Respondent.	Case No. D1-1996-69949 OAH No. L2006040141

DECISION AFTER NONADOPTION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Los Angeles, California, on January 7, 8, 9, 14, 16, 17, 22, 23, and 24, 2008.

E. A. Jones III, Deputy Attorney General, represented complainant David T. Thornton, Executive Director of the Medical Board of California.

John C. Mulvana, Attorney at Law, represented respondent.

Complainant seeks to discipline respondent's medical license on grounds of alleged gross negligence, repeated negligent acts, incompetence, failure to maintain liability insurance, failure to timely report the death of a patient, failure to maintain adequate records, filing of false claims, dishonest acts, and failure to comply with terms and conditions of probation in connection with the care and treatment of three patients. Respondent denies the allegations and asserts that cause for discipline does not exist.

Oral and documentary evidence, and evidence by oral stipulation on the record, was received at the hearing and the matter was submitted for decision.

The proposed decision of the administrative law judge was submitted to the Medical Board of California (hereafter "Board") on February 25, 2008. After due consideration thereof, the Board declined to adopt the proposed decision and thereafter on April 30, 2008 issued an Order of Nonadoption and subsequently issued an Order Fixing Date for Submission of Written Argument. On August 21, 2008, the Board issued an order delaying the decision for good cause until November 24, 2008. On October 9, 2008, the Board issued a Notice of Hearing for Oral Argument. Oral argument was heard on November 6, 2008. The time for filing written argument in this matter having expired, written argument having been filed by both parties and such written argument, together with the entire record, including the transcript of said hearing, having been read and

considered, pursuant to Government Code Section 11517, the board hereby makes the following decision and order:

FACTUAL FINDINGS

Parties

1. Complainant filed the Accusation in his official capacity.

2. On June 26, 1978, the Board issued Physician's and Surgeon's Certificate Number G36859 to respondent. The certificate is in effect, and has been in effect at all times material.

3. On October 23, 1991, effective November 22, 1991, the Board adopted a stipulated settlement revoking respondent's medical certificate, staying the revocation, and placing the certificate on probation for five years, on specified terms and conditions, which included a 60-day suspension. Respondent admitted that he had been convicted of violating 26 U.S.C. sections 7201 (causing to be prepared and signing a fraudulent corporate tax return) and 7206, subdivision (1) (filing a fraudulent personal tax return.) Probation was terminated early, on December 6, 1994.

4. Effective September 11, 2003, following another stipulated settlement, the Board revoked respondent's certificate, stayed the revocation, and placed the certificate on probation for seven years on specified terms and conditions, including that he obey all laws (condition 7). One of the conditions was an actual certificate suspension of 120 days. The Disciplinary Order resulted from an accusation that charged respondent with gross negligence, repeated negligent acts, incompetence, failure to maintain adequate records, filing false insurance claims, making false statements, and altering medical records, in connection with the care and treatment provided to nine patients during the period of August 1994 to November 1998. Respondent admitted the truth of all the allegations.

5. Respondent was born in Canada, and graduated from McGill University School of Medicine, in Montreal, Canada, in 1977. He completed three years of post-graduate training in general surgery in Southern California, two at Harbor General Hospital in Torrance and one at White Memorial Hospital in Los Angeles. He then returned to McGill University for training in plastic and reconstructive surgery, from 1980 to 1982. After completing his training at McGill University, and at other times during his career, respondent has spent time with various plastic surgeons, learning their techniques. Respondent has acquired knowledge regarding the use of anesthesia in medical school courses, post graduate training, and observation of other physicians. In December 1983, respondent obtained a certification from the American Board of Plastic Surgery.

6. In 1982, respondent opened his medical plastic and reconstructive surgery practice in Southern California. He has administered anesthesia in many of his cases.

Respondent has the training and experience to administer Propofol, an anesthetic at issue in this proceeding.

7. In 1996, respondent moved his offices to a larger facility, and opened a separate outpatient surgery center which he called Madison Surgery and Laser Center (Madison). There are two operating rooms at Madison, one of which is larger. There is also a separate recovery room. Madison has received State of California and federal certifications authorizing the performance of minor surgical procedures. State recertification inspections occur on a yearly basis.

8. A requirement for certification as a surgery center is the maintenance in good order of a "crash cart," a container for items needed to revive a patient during emergency cardiopulmonary events. Respondent has such a cart, housed in a red Sears Craftman toolbox. The crash cart is maintained in the operating room, and was present on the pertinent date of March 26, 2004.

9. One of the physicians who perform surgery at Madison is Mario Decunto, M.D. (Decunto). Dr. Decunto specializes in obstetrics/gynecology (ob/gyn). Since 1983, Dr. Decunto has been training with respondent to perform various plastic surgery procedures. As of March 2006, Dr. Decunto performed his own surgeries and assisted respondent in some of respondent's surgeries.

Patient J.H.[1]

10. The patient, a 47 year-old woman at the time, presented to Madison on March 2, 2001, to obtain a consultation regarding the cost of various cosmetic procedures. Respondent recalled that she had been a patient in 1997 or 1998, and had been treated for sun damage. He examined her, noted several pigmented lesions on her face and neck, and charted a plan to rule out basal cell carcinoma. The patient agreed to treatment if covered by her medical insurance. Respondent provided the prices for the cosmetic procedures, which included a face and brow lift. Respondent also injected Botox in J.H.'s forehead, for which she paid $475.[2]

11. a. The patient returned on March 26, 2001, for treatment of her face. J.H. testified that it was for the removal of the "moles" respondent had identified in the prior visit. Respondent obtained a pertinent history and physical before the surgery. Respondent again noted multiple lesions and skin conditions. His diagnoses were: "1. Multiple tumors of the face, greater

[1] Initials have been used to protect the patients' privacy.

[2] Findings regarding this patient are based on the medical records and the testimonies of respondent and the patient. When in conflict, respondent's testimony has been credited over that of J.H. He presented more credible testimony, corroborated by contemporaneous records that included chart notes and billing records. In addition, J.H. lacked recollection regarding critical details, such as whether she had received Botox injections, and she presented partially inconsistent testimony.

than 2.5 cm. Rule out basal cell carcinoma. [¶] 2. Multiple tumors of the neck, greater than 2.5 cm., with irritation, hyperpigmentation. Rule out basal cell carcinoma. [¶] 3. Tumor of the left brow, greater than 1 cm. Rule out melanoma. [¶] 4. Multiple vascular lesions, actinic keratosis and premalignant lesions of the chest, back and shoulders, greater than 10 sq., cm, requiring laser surgery." He planned to excise the tumors of the face, neck and left brow with a complex skin repair on that day, and to perform laser destruction on the vascular lesions and actinic keratosis of the back, shoulders and chest at a later date. The patient consented to the procedure, after its risks and benefits were explained.

b. In accordance with his plan, respondent excised the facial and neck lesions, using a local anesthetic, and prepared an operative report consistent with his actions. Respondent appropriately performed a complex closure of the wound on J.H.'s cheek in order to obtain better results and maintain the patient's cosmetic appearance.

c. Respondent also recommended creams to treat the face, which the patient purchased for $232.

12. Respondent submitted skin specimens to a pathologist for analysis, and the resulting report was negative for carcinoma.

13. a. On April 2, 2001, J.H. returned to respondent's office at Madison for follow-up of the March 26, 2001 surgery and for laser treatment of her other lesions. The patient was doing well, and sutures were removed from her cheek.

b. Respondent discussed the risks and benefits of the procedure with the patient, and obtained her oral informed consent to the procedure. He did not have the patient sign a written consent form because the procedure was relatively minor. He had documented the discussion of a two-step plan, which included the laser procedure, on the March 26, 2001 history and physical chart note; after a discussion of the plan, respondent wrote, "The patient gives her informed consent to proceed with the necessary reconstructive surgery." The experts who testified regarding the subject, Angelo Capozzi, M.D. (Capozzi) and Melvin Shiffman, M.D. (Shiffman), called by complainant and respondent, respectively, agreed that a signed written consent form was not required for the procedure if the patient gave an informed oral consent.

c. Respondent performed the laser procedure, which he described in the operative report as "Laser destruction of multiple tumors of the chest, back and shoulders, greater than 10 sq., cm." He again used local anesthesia and did not prepare a separate anesthesia chart note. He destroyed over 22 lesions, ranging in size from 8 mm to 1.3 cm, using a "pulsed dye laser at 14 joules, 20 milliseconds, and a 7 mm spot size." Although it is alleged that respondent's failure to use a PDT (photo dynamic therapy) laser constituted a deviation from the standard of care, complainant's expert on this point, Dr. Capozzi, conceded that the standard did not require such laser and that some physicians have had success without PDT.

14. Respondent used local anesthesia for the March 26 and April 2, 2001, procedures. As required by the standard of care, respondent documented his use of the local anesthetic, but

did not prepare a more complete anesthesia note. Respondent's expert, Richard Hochman, M.D. (Hochman) credibly testified, with partial corroboration by complainant's expert Dr. Capozzi, that a formal anesthesia record is not required for administration of local anesthesia for the type of procedures J.H. underwent.

15. Dr. Capozzi testified that the March 26 and April 2, 2001 procedures were not medically necessary. His testimony is unpersuasive. Dr. Capozzi's conclusions were largely based on the patient's statements regarding the nature of the lesions. Unlike respondent, Dr. Capozzi did not examine the patient to evaluate the seriousness of the lesions. Moreover, Dr. Capozzi's direct examination testimony is partially inconsistent with that given on cross-examination. He defined "medically necessary" procedure as one that provides some benefit to the patient, and conceded on cross-examination that the removal of the pre-cancerous lesions had some prophylactic benefit for the patient.

16. J.H.'s next office visit was on May 18, 2001, for follow-up, and respondent removed a remaining suture. As was his custom, respondent wrote the billing code for the procedure on his chart note, to facilitate office staff billing. The code he wrote was "10160," or aspiration and removal of a foreign body. The computer program used by respondent's office did not have sufficient space for the entire written description and the staff dropped the words after "aspiration."

17. On August 1, 2001, J.H. sought consultation regarding lesions on her left leg. Respondent also injected Botox on J.H.'s face, for which she paid $400.

18. a. Respondent billed J.H.'s insurance for the procedures performed on March 26 and April 2, 2001. As was customary, he billed separately for his services as the surgeon and for those of the surgery center, Madison. His bill for March 26, 2001 was $2,050, and that for Madison, which included operating room usage, recovery room usage, medical supplies, and pharmacy/anesthesia supplies, was $4,125. The numbers for the April 2, 2001, procedure were $1,000 and $2,567, respectively.

b. It was not established that respondent's charges were excessive, unreasonable, or false, given the procedures performed and the costs to maintain the equipment and operating room.

19. J.H.'s private insurance paid $2,053.67 for the March 26, 2001 procedure, but denied payment for the April 2, 2001, purportedly as not medically necessary.

20. On January 21, 2005, after delays resulting from a number of factors, including the processing of insurance claims, the incorrect billing to J.H.'s ex-husband's address, and a change of address by J.H., the patient received a bill from respondent in the amount of $12,052.05. The largest portions of the bill stemmed from the March 26 and April 2, 2001 procedures, and included $3,103.72 in interest charges. Respondent and J.H. were unable to reach a satisfactory accommodation regarding the bill, and J.H. filed a complaint with the Board.

Patient J.M.

21. The patient, a woman born on September 26, 1964, had seen respondent for hair removal in 2001 or 2002.

22. a. J.M. presented on February 6, 2004, seeking fuller lips. Respondent explained the options of Bellergan and Dermalogen fat injections, together with each one's costs, benefits, and risks. The risks of Bellergan discussed included bumps, irregularities, bleeding, and fat reabsorbtion, and respondent documented the discussion.

b. J.M. gave her oral consent to the fat injections, and opted to try both to see if she would like the results.

c. Respondent proceeded to inject one cubic centimeter (cc) of Bellergan in J.M.'s upper lip and one-half cc of Dermalogen in the lower lip.

23. a. The patient underwent another procedure on March 1, 2004. Respondent and Dr. Decunto removed fat from J.M.'s abdomen and injected it in her lips, 4.5 cc in the upper lip and 2.5 cc in the lower lip.

b. Respondent explained the risks of the procedure and obtained the patient's written informed consent. J.M. signed a "Consent Form for Surgery," authorizing Dr. Decunto to perform "fat grafts to face and lips." She also signed a separate form indicating that "The following risks and side effects, among others, have been specifically made clear to me: 1. Temporary bruising, swelling and numbness; 2. Probably will need to be repeated; 3. Asymmetry; 4. Local infection; 5. May not be permanent; 6. Irregularity and contouring deficiency; 7. Need to repeat procedure."

c. Respondent used local anesthesia for the surgery, and charted its use in accordance with the standard of care.

d. Surgery commenced at 2:30 p.m. and concluded one hour later. Respondent did not prepare an operative report, instead noting pertinent facts in a brief progress note. Respondent's failure to prepare an operative report constitutes a deviation from the standard of care.

Patient A.B.

24. The patient, a 29-year-old woman, first presented to respondent's office on March 11, 2004, inquiring about various cosmetic procedures. She had undergone prior surgery and wanted to improve the appearance of a scar in her abdomen from a prior surgery. She also wanted to reduce fat deposits in her abdomen, arms, back, sides, and thighs. The patient completed a brief medical history questionnaire, which disclosed her prior surgeries as "tummy tuck, liposuction, breast lift/aug[mentation]." Respondent performed a brief physical examination, suggested a lipectomy, and discussed the risks, benefits, and out-of-pocket costs of

the procedure. Respondent also treated the scar with a pulsed dye laser.

25. On March 13, 2004, A.B. spoke to respondent by telephone and, after additional discussion of the risks and benefits of the procedure, agreed to undergo surgery. Respondent provided preoperative instructions, including the start of vitamins and minerals.

26. a. A.B. did not present any history of pulmonary disease, diabetes mellitus, hypertension, or coronary artery disease. She was five-feet, six-inches tall and weighed approximately 190 pounds.

b. Respondent obtained laboratory results from Methodist Hospital of Southern California, which results were based on blood collected on December 13, 2003. The results of the comprehensive metabolic, complete blood count, and differential panels were normal, with the exception of a slightly elevated glucose level and a slightly low bicarbonate level.

c. Complainant called Michael C. Ciano, M.D. (Ciano) as an expert witness. Dr. Ciano has been a practicing plastic surgeon in Los Angeles since 1982, and has performed many liposuction procedures. He holds a certification from the American Board of Plastic Surgeons and has held a clinical teaching position with the University of California, Los Angeles, School of Medicine. In his opinion, the standard of care required more recent blood analysis laboratory results because liposuction involves substantial blood loss and because the patient was a menstruating woman. On the other side, Dr. Hochman, who has similar experience and qualifications, testified that surgeons, in this case Dr. Decunto, have discretion regarding how recent laboratory reports to rely on. In Dr. Hochman's opinion, it was not outside the standard of care for Dr. Decunto to have used three-month-old laboratory results from a healthy young woman for a liposuction procedure that does not involve significant blood loss. In light of Dr. Hochman's well-reasoned opinion, complainant has not established a deviation from the standard of care by clear and convincing evidence.

27. The patient presented for surgery on March 26, 2004. Respondent had planned to provide anesthesia and Dr. Decunto was to be the surgeon. Respondent did not intend to provide general anesthesia, but planned to provide what he referred to as "conscious sedation," a state where the patient, although sedated, remains able to respond to verbal or physical stimuli. Dr. Hochman referred to it as "light general anesthesia," and noted surgeons refer to the state as "twilight sleep."

28. At approximately 5:20 a.m., respondent and Dr. Decunto discussed the risks of the procedure with A.B. and provided her with consent forms. One document was entitled "Suction Assisted Lipectomy (SAL) Information Sheet." Two forms listed the risks of lipoplasty and fat grafting, respectively. The lipoplasty form stated, "The following risks and side effects, among others, have been specifically made clear to me:", and listed: death; disfigurement; asymmetry; nerve injury; unsatisfactory scarring; infection; need for secondary procedures, possibly skin excision; contouring irregularities; changes in skin color; swelling – persistent edema; tape reaction or tape burns; collection of fluid –seroma, hematoma; skin

breakdown; fat embolism; shock; in patients over the age of 40, increased risk of redundant skin and lumpiness. A "Consent Form for Surgery" authorized Dr. Decunto to perform "liposuction back, flanks, arms, axilla and abdomen, release suprapubic contracture with fat graphs, possible tissue rearrangement, suprapubic area, possible fat gra[fts] right arm." The patient signed the forms.

29. An intravenous line (IV) was started at approximately 5:30 a.m., while the patient was in the recovery room. A.B. started receiving intravenous saline fluids at 5:30 a.m. Preoperative antibiotics were administered at 5:30 and 5:40 a.m. However, A.B. had second thoughts about proceeding with surgery, and, at approximately 5:45 a.m., surgery was stopped.

30. Respondent called A.B.'s husband for him to pick her up. A.B.'s husband came to Madison, and spoke to the patient. They later spoke to Dr. Decunto, who assured them that he had successfully performed similar procedures in the past. After these discussions, the patient decided to proceed with surgery, but asked for something to calm her down. At 6:30 a.m., Dr. Decunto administered 5 milligrams (mg) of Valium through the IV. A.B.'s husband and Dr. Decunto then accompanied A.B. back to the operating room. Respondent did not participate in the discussions, but was informed later that the patient decided to proceed with surgery.

31. Respondent and Dr. Decunto, the latter called as a witness by complainant, provided testimony regarding the events of March 26, 2004. Their testimony was generally consistent and the findings regarding events during the surgery are based on their testimony and the anesthesia record, which is also materially consistent with the physicians' testimony. Areas in which their testimony contains material differences are discussed in greater detail.

32. Respondent prepared the anesthesia record, a one-page contemporaneous chart note containing timed entries of vital signs, drugs used, and other pertinent information. However, respondent failed to enter the following information, as required by the standard of care: the patient's level of consciousness, at 15-minute intervals; the patient's temperature; and, an indication that electrocardiogram (ECG) monitoring was employed. Once Propofol was administered, the standard of care required charting of vital signs at least every five minutes; respondent's entries between 7:22 and 8:26 a.m. were recorded at six-minute (once), eight-minute (once), or ten-minute (four) intervals.[3]

33. The patient was placed in the prone position on the operating table. An airway tool, described by respondent as a "bent shoe horn" and in the largest size used for female patients, was placed in A.B.'s mouth to keep the airway open and to keep the tongue out of the way. Supplemental oxygen at the rate of four liters per minute was provided via nasal cannula from large tanks kept in the operating room.

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[3] This finding is based on the credible and persuasive testimony of complainant's expert, Roger F. Donenfeld (Donenfeld.)

34. Respondent's primary position was by the patient's head, seated on a stool with wheels. A counter with supplies and medications was to his left. Blood pressure, EGC, and pulse oximeter monitors were in place and the instruments' screens were on a cart stationed on the side of the patient. The screens were to respondent's left and visible to him during the procedure. In addition to the visual information, the monitors emitted sounds. A temperature strip was placed in the patient's forehead at the start of the procedure, and showed a temperature of 98 degrees; a second strip used later in the procedure measured a temperature of 96 degrees. Respondent was in a position to observe the patient's face, her skin color, and physical signs of breathing.

35. Respondent and Dr. Decunto employed two surgical technicians as assistants during the procedure, Jeanette Margolis and Gina Corcoran (Corcoran), neither of whom was trained as a registered nurse.

36. The patient appeared anxious at 6:51 a.m., and respondent provided another 10 mg of Valium. More sedation was given at 7:00 a.m., in the form of 10 mg of Valium and 25 mg of Demerol. A.B. was still anxious at 7:10 a.m., and respondent administered another 10 mg dose of Valium, this time accompanied by one-quarter ampule of Thorazine, a tranquilizer. At 7:14 a.m. respondent administered 10 mg of Propofol, a quick-acting, short-lived anesthetic, and another 5 mg of Valium, to commence the procedure. The tumescent solution, containing four liters of tumescent fluid, 24 cc of 2 percent lidocaine and 2 cc of epinephrine, was also administered at 7:14 a.m. Respondent induced subsequent 10 mg doses of Propofol at 7:22, 7:30, 7:50, and 8:10 a.m., or a total of 50 mg (5 cc). Respondent alternated the Propofol with another short-acting anesthetic, ketamine, which was applied in three 25 mg doses, at 7:17, 7:40, and 8:00 a.m., and which was accompanied by Demerol, 25 mg, 12.5 mg, and 12.5 mg, respectively.

37. The chart does not record the order in which the surgery proceeded, but respondent presented testimony based on his recollection and the typical progression of similar procedures. Thus, the flanks were done first, each taking approximately 10 minutes; the saddles were next, each at 3-5 minutes; the posterior back and the thighs followed; and the arms and axilla were done after those areas.

38. Respondent testified that he assisted Dr. Decunto by performing the liposuction of the inner thighs, a task that took him about three to four minutes, or one-and-one-half to two minutes for each thigh, starting at approximately 7:41 or 7:42 a.m. Respondent stated that he performed the liposuction from his station by the head of the patient by reaching toward her thighs, and that he was able to continue to monitor the patient while engaged in the procedure; the monitors were still in his line of sight and his head was actually closer to the patient's head, enabling him to hear her breathing. Respondent also noted that the inner-thigh fat is one of the easiest to aspirate, not as physically demanding on the surgeon as other areas.[4]

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[4] Respondent has ceased performing more physically demanding surgical procedures because of limitations resulting from neck injuries.

39. Dr. Decunto testified that respondent suctioned the inner thigh areas. He stated that respondent moved from the area near the head of the patient closer to her thighs. Dr. Decunto estimates that it took respondent about 10 minutes to complete work on both thighs. He does not recall what respondent did next. Of critical importance, however, Dr. Decunto did not recall where respondent was or how much time had passed between the time respondent performed liposuction on the thighs and the time the patient experienced difficulty breathing, as set forth below. While the ALJ found that this lack of recollection shows, consistent with respondent's testimony, that a significant period of time had passed between the two events, the panel finds that this is not relevant since it takes time for oxygen desaturation to occur.

40. Respondent testified that he was able to continuously monitor the patient's condition and that he charted her vital signs at pertinent intervals. As of 8:20 a.m., her breathing, color, and vital signs were at acceptable levels. She was responsive to stimuli, but was not screaming in pain.

41. Respondent testified that he continued to monitor the patient after 8:20 a.m. At 8:26 a.m., both respondent and Dr. Decunto heard the pulse oximeter alarm. The monitor showed an abnormally low reading of 60. Respondent checked that the pulse oximeter lead was still in place in the patient's finger. When he confirmed placement, he directed one of the assistants, Corcoran, to bring another pulse oximeter machine from the recovery room. Less than two minutes later, at 8:28 a.m., the new pulse oximeter was in place and it provided a still low blood oxygen saturation reading of 65. By this time, the patient's lips were turning blue, her blood pressure was dropping (70/40), and the ECG monitor was erratic.

42. While Corcoran was retrieving the new pulse oximeter, respondent held the patient's neck back and inserted a new, larger airway tool to improve oxygenation. Dr. Decunto ceased performing surgery and started providing additional oxygen via a portable oxygen bag with a pump, or "ambu bag." This device delivered approximately eight liters per minute. Dr. Decunto and the assistant performed cardiopulmonary resuscitation, and respondent administered medication to the patient to reverse the respiratory depressant effects of Demerol and Valium. The assistant was directed to call 911, which she did. Engaged in the foregoing activities, neither respondent nor Dr. Decunto were able to intubate the patient.

43. The experts disagreed regarding the need to intubate the patient. Dr. Ciano testified that the standard of care required immediate intubation. Dr. Hochman countered that such intubation would interfere with chest compressions and that the ambu bag with the airway management underway was appropriate. In light of the disparity of opinion, each of which has its merits, complainant did not establish, by clear and convincing evidence, that the standard of care required respondent to intubate the patient prior to the arrival of the paramedics.

44. Paramedics arrived at 8:35 a.m. and took over management of the patient. A.B. was in full cardiac arrest; she did not have a pulse and was not breathing. The paramedics intubated her and performed defibrillation, twice.

45. The paramedics made the decision to take A.B. to Torrance Memorial Hospital (TMH), the closest medical center with an emergency room. The patient arrived at TMH at 8:54 a.m.

46. On March 26, 2004, respondent had agreements with San Pedro Peninsula Hospital, Daniel Freeman Memorial Hospital, and Community Hospital of Gardena, local medical centers with emergency rooms in the event such was needed for a patient undergoing outpatient surgery at Madison. Having such arrangements comports with the standard of care and respondent's obligation to patients undergoing outpatient surgery at Madison.

47. On March 26, 2004, respondent did not have a transfer agreement or medical privileges at TMH. This failure does not constitute a deviation from the standard of care, as respondent did not know which medical center the paramedics would take the patient. In addition, the surgeon in the procedure, Dr. Decunto, had medical privileges at TMH and followed the patient to the hospital to provide information to emergency room personnel and follow-up care to A.B.

48. Emergency physicians at TMH continued treatment to stabilize the patient, and, employing aggressive resuscitative measures, were able to restore cardiac and pulmonary function to A.B.

49. A chest x-ray taken at 9:22 a.m. showed that the endotracheal tube had been incorrectly inserted into the pulmonary right main stem. At 10:20 a.m. the tube was withdrawn by two centimeters and placed into proper position. Having placed the tube too far into the right lung deprived the left lung of the benefits of oxygen and resulted in suboptimal oxygenation.

50. The patient was transferred to the intensive care unit at TMC, where she remained in a comatose condition. An electroencephalogram on March 28, 2004, revealed no electrical brain activity. Mechanical ventilation was withdrawn on March 30, 2004, and the patient was pronounced dead at 8:30 a.m.

51. The Los Angeles County Department of Coroner conducted an autopsy, and Louis A. Pena, M.D., concluded that the death had been accidental, the result of bronchopneumonia due to probable anoxic encephalopathy.[5]

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[5] The experts disagreed about the cause of the patient's demise. Complainant's experts, primarily Dr. Donenfeld, placed blame on respondent's failure to properly monitor the patient's vital signs. Respondent's experts, particularly Dr. Shiffman, noted that unforeseen, extraordinary complications, such as an embolism, may have caused the patient's death.
Supporting Dr. Shiffman's position, the coroner did not rule out a fat embolism. However, resolution of this conflict is not necessary to evaluate respondent's actions in light of the standard of care or the potential risks of deviations from the standard. The panel agrees that cause of death is not relevant to an evaluation of whether respondent's actions deviated from the standard of care. He is not charged with causing the patient's death.

Additional Findings Regarding Alleged Deviations from the Standard in the Care of A.B.

52. a. The standard of care requires direct and continuous monitoring of the patient, particularly her respiratory ability, by the person administering the anesthesia. As Dr. Donenfeld noted, this is particularly critical given the potential for the Propofol, in combination with the other sedatives, to send the patient into a deep sedation stage. Also, monitoring is critical because some of the drugs administered, namely, Demerol and Valium, tend to depress respiration.[6]

b. Respondent deviated from the standard of care by engaging in liposuction of the inner thighs while responsible for monitoring the sedated patient. Because he was engaged in surgery, his attention was, at best, divided between both tasks, and his monitoring was therefore suboptimal. The deviation from the standard of care is an extreme one because of the grave potential risk to the patient from such substandard monitoring.

53. It was not established that respondent used Propofol in an inappropriate dosage. As Dr. Hochman, one of the pioneers in the use of Propofol in Southern California, testified, the 50 mg administered represent a fraction of that used for general anesthesia, and was appropriate for the patient's size and condition. Moreover, as Dr. Hochman noted, the dosages were administered in a gradual manner, consistent with need and drug action.

54. a. Respondent did not have medical malpractice insurance on March 26, 2006, which failure constitutes a deviation from the standard of care. He had set aside a sum in the event he had to settle any claims.

b. In March 2004, Dr. Decunto had medical malpractice insurance.

55. On March 26, 2004, respondent's Advanced Cardiac Life Support (ACLS) certification had expired, and the failure to have a current certification constitutes a deviation from the standard of care.

56. At 9:45 a.m., on March 26, 2004, a very low rectal temperature of 92.4 degrees was obtained from the patient at TMH. Dr. Donenfeld opined that such low temperature was indicative of respondent's failure to maintain the patient's body temperature at the appropriate normal level as required by the standard of care. On direct examination, when he initially rendered his opinion, Dr. Donenfeld assumed that the temperature had been taken upon A.B.'s arrival at TMH. He did not alter his opinion on cross-examination, when presented with the actual time. However, as Dr. Hochman pointed out, a significant period of time had passed between surgery and the rectal temperature measure, the patient had undergone a significant change in condition, and she had been exposed to the outside temperature during her transfer to

[6] This finding is based on the testimony of Dr. Donenfeld, which was consistent with published guidelines and was only partially contradicted by that of Dr. Hochman.

TMH, all of which make it difficult to reach precise conclusions regarding temperature in the operating room. Moreover, respondent testified that he measured the patient's temperature on two occasions and that it was normal in each instance. In these circumstances, the low temperature obtained at TMH is not sufficient to establish that respondent, or Dr. Decunto as the surgeon, failed to properly maintain the patient's body temperature in the operating room.

57. Respondent did not notify the Board, within 15 days of A.B.'s death, of the patient's death, which failure constitutes a deviation from the standard of care.

Adequacy of Respondent's Record Keeping

58. Respondent's charts for the three patients were largely illegible, which constitutes a deviation from the standard of care. In fact, respondent himself had difficulty reading his own writing at the hearing.

Character/Skill References

59. Respondent called three character witnesses. David H. Smith, M.D., a colleague since 1991, has performed between 50 and 100 procedures with respondent. He described respondent as a skilled and caring physician. Maria Basch and Rabbi Eli Hecht applauded respondent's many charitable community services.

60. Dr. Decunto testified that respondent is a well-trained and competent physician.

Other Allegations and Arguments

61. Except as set forth in this Decision, all other allegations in the accusation and petition to revoke probation, and all other arguments by the parties, lack merit or constitute surplusage.

Respondent's Credibility

62. Respondent was sworn in and made a statement to the panel during oral argument. The panel assessed respondent's credibility, particularly with regard to his statements that he monitored the patient continually even while performing liposuction, and found respondent's statements not credible. During oral argument, respondent repeatedly asserted that he could see the patient's face since it was turned to the side. However, the record reflects that a sheet was covering her face and it was not until the sheet was lifted that the patient's cyanotic condition was observed. Respondent also stated during oral argument that he was "listening to her chest." However, the patient was in a prone position and respondent could not have listened to her chest without either turning her over or positioning himself under the operating table—neither of which occurred. The panel, having had the opportunity to hear and observe respondent, finds that respondent is not trustworthy, his testimony is not credible, and he has proven he is a danger to the public.

63. During oral argument, respondent showed no real contrition or remorse, but rather commented on the financial problems the current action had caused him and his family.

64. The panel finds revocation is the only appropriate order in this case. In light of his conduct in acting both as anesthesiologist and surgeon and his failure to recognize the significant danger that such dual responsibilities create for a patient, revocation of respondent's license is necessary to protect the public. This is respondent's third disciplinary action and he was on probation at the time of A.B.'s surgery. Respondent has shown that probation on terms and conditions is not sufficient to provide public protection and he therefore cannot be rehabilitated via a period of such probation.

LEGAL CONCLUSIONS

1. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code[7] section 2234, subdivision (b), in that he engaged in gross negligence, by reason of factual finding numbers 38, 39, 40, and 52.b.

2. Cause exists to discipline respondent's certificate pursuant to section 2234, subdivision (c), in that he engaged in repeated negligent acts, by reason of factual finding numbers 23.d., 32, 54, 55, 57, and 58.

3. The established violations are insufficient to establish that respondent was incompetent in his care and treatment of any of the three patients. Therefore, cause does not exist to discipline respondent's certificate pursuant to section 2234, subdivision (d).

4. Cause exists to discipline respondent's certificate pursuant to section 2216.2, in that respondent did not maintain medical liability insurance in March 2004, by reason of factual finding number 54.

5. Cause exists to discipline respondent's certificate pursuant to section 2240, in that respondent did not notify the Board of A.B.'s death in a timely manner, by reason of factual finding number 57.

6. Cause exists to discipline respondent's certificate pursuant to section 2266 in that he failed to maintain adequate and accurate records, by reason of factual finding numbers 32 and 58.

7. The violation of sections 2216.2, 2240, 2234, and 2266 set forth in legal conclusion numbers 1, 2, 4, 5, and 6, constitute violations of condition number 7 (obey all laws) of respondent's probation with the Board.

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[7] All further references are to the Business and Professions Code.

8. Except as set forth in legal conclusion numbers 1, 2, 4, 5, and 6, additional cause for discipline pursuant to sections 810 (false claims), 2234, subdivisions (a) or (b), or 2234, subdivision (e), (dishonest acts), or additional violations of probation, have not been established.

9. All evidence presented in mitigation and rehabilitation, as well as that presented in aggravation, has been considered. The established act of gross negligence is very serious, and the charting errors represent repeated violations. Respondent's certificate has been discipline twice before, and he was on probation at the time he provided care to A.B. and J.M. Accordingly, significant discipline is necessary for the protection of the public. At the same time, the purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection. (Hughes v. Board of Architectural Examiners (1998) 17 Cal.4th 763, 784-786; Bryce v. Board of Medical Quality Assurance (1986) 184 Cal.App.3d 1471, 1476). On balance, the order that follows is, therefore, necessary and sufficient for the protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G36859 issued to respondent Lawrence Saks, M.D. is hereby revoked.

This decision shall become effective at 5:00 p.m. on December 22, 2008.

IT IS SO ORDERED this 21st day of November, 2008.

BARBARA YAROSLAVSKY
Chairperson, Panel B
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	)	
LAWRENCE SAKS, M.D.	)	**OAH NO: L2006040141**
Physician's & Surgeon's Certificate # G 36859	)	MBC Case No: D1-1996-69949
Respondent	)	

ORDER DELAYING DECISION

Pursuant to Business & Professions Code 2335 and Section 11517 of the Government Code, the Medical Board of California, finding that a further delay is required by special circumstances, hereby issues this order delaying the decision for no more than 30 days from October 25, 2008, (when the 100 day period expires) to November 24, 2008.

The reason for the delay is as follows: This case is on the agenda for the Board's meeting of November 6, 2008. Therefore, the Board needs additional time to discuss and consider written and oral arguments by the parties.

DATED: August 21, 2008

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAWRENCE SAKS, M.D.**	Case No.: D1-1996-69949
Physician's & Surgeon's Certificate No.: G 36859	OAH No.: No.L2006040141
Respondent	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** The Medical Board of California will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including in particular, argument directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact : Kennedy Court Reporters, 920 W. Seventeenth Street, Second Floor, Santa Ana, CA 92706. The telephone number is: (714) 835-0366 - FAX # (714) 835-0641.

To order a copy of the exhibits, please contact: Office of Administrative Hearings, 320 West Fourth Street, Suite 630, Los Angeles, CA 90013. The telephone number is: (213) 576-7200 - FAX # (213) 576-7244.

In addition to written argument, oral argument will be scheduled if any party files with the Board within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2624

Dated: April 30, 2008

Barbara Yaroslavsky
Panel B, Chair
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: LAWRENCE SAKS, M.D., Physician's and Surgeon's Certificate Number G36859 Respondent.	Case No. D1-1996-69949 OAH No. L2006040141

PROPOSED DECISION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Los Angeles, California, on January 7, 8, 9, 14, 16, 17, 22, 23, and 24, 2008.

E. A. Jones III, Deputy Attorney General, represented complainant David T. Thornton, Executive Director of the Medical Board of California (Board).

John C. Mulvana, Attorney at Law, represented respondent.

Complainant seeks to discipline respondent's medical license on grounds of alleged gross negligence, repeated negligent acts, incompetence, failure to maintain liability insurance, failure to timely report the death of a patient, failure to maintain adequate records, filing of false claims, dishonest acts, and failure to comply with terms and conditions of probation in connection with the care and treatment of three patients. Respondent denies the allegations and asserts that cause for discipline does not exist.

Oral and documentary evidence, and evidence by oral stipulation on the record, was received at the hearing and the matter was submitted for decision.

FACTUAL FINDINGS

Parties

1. Complainant filed the Accusation in his official capacity.

2. On June 26, 1978, the Board issued Physician's and Surgeon's Certificate Number G36859 to respondent. The certificate is in effect. and has been in effect at all times material.

3. On October 23, 1991, effective November 22, 1991, the Board adopted a stipulated settlement revoking respondent's medical certificate, staying the revocation, and placing the certificate on probation for five years, on specified terms and conditions, which included a 60-day suspension. Respondent admitted that he had been convicted of violating 26 U.S.C. sections 7201 (causing to be prepared and signing a fraudulent corporate tax return) and 7206, subdivision (1) (filing a fraudulent personal tax return.) Probation was terminated early, on December 6, 1994.

4. Effective September 11, 2003, following another stipulated settlement, the Board revoked respondent's certificate, stayed the revocation, and placed the certificate on probation for seven years on specified terms and conditions, including that he obey all laws (condition 7). One of the conditions was an actual certificate suspension of 120 days. The Disciplinary Order resulted from an accusation that charged respondent with gross negligence, repeated negligent acts, incompetence, failure to maintain adequate records, filing false insurance claims, making false statements, and altering medical records, in connection with the care and treatment provided to nine patients during the period of August 1994 to November 1998. Respondent admitted the truth of all the allegations.

5. Respondent was born in Canada, and graduated from McGill University School of Medicine, in Montreal, Canada, in 1977. He completed three years of post-graduate training in general surgery in Southern California, two at Harbor General Hospital in Torrance and one at White Memorial Hospital in Los Angeles. He then returned to McGill University for training in plastic and reconstructive surgery, from 1980 to 1982. After completing his training at McGill University, and at other times during his career, respondent has spent time with various plastic surgeons, learning their techniques. Respondent has acquired knowledge regarding the use of anesthesia in medical school courses, post graduate training, and observation of other physicians. In December 1983, respondent obtained a certification from the American Board of Plastic Surgery.

6. In 1982, respondent opened his medical plastic and reconstructive surgery practice in Southern California. He has administered anesthesia in many of his cases. Respondent has the training and experience to administer Propofol, an anesthetic at issue in this proceeding.

7. In 1996, respondent moved his offices to a larger facility, and opened a separate outpatient surgery center which he called Madison Surgery and Laser Center (Madison). There are two operating rooms at Madison, one of which is larger. There is also a separate recovery room. Madison has received State of California and federal certifications authorizing the performance of minor surgical procedures. State recertification inspections occur on a yearly basis.

8. A requirement for certification as a surgery center is the maintenance in good order of a "crash cart," a container for items needed to revive a patient during emergency cardiopulmonary events. Respondent has such a cart, housed in a red Sears Craftman tool box. The crash cart is maintained in the operating room, and was present on the pertinent date of March 26, 2004.

9. One of the physicians who perform surgery at Madison is Mario Decunto, M.D. (Decunto). Dr. Decunto specializes in obstetrics/gynecology (ob/gyn). Since 1983, Dr. Decunto has been training with respondent to perform various plastic surgery procedures. As of March 2006, Dr. Decunto performed his own surgeries and assisted respondent in some of respondent's surgeries.

Patient J.H.[1]

10. The patient, a 47 year-old woman at the time, presented to Madison on March 2, 2001, to obtain a consultation regarding the cost of various cosmetic procedures. Respondent recalled that she had been a patient in 1997 or 1998, and had been treated for sun damage. He examined her, noted several pigmented lesions on her face and neck, and charted a plan to rule out basal cell carcinoma. The patient agreed to treatment if covered by her medical insurance. Respondent provided the prices for the cosmetic procedures, which included a face and brow lift. Respondent also injected Botox in J.H.'s forehead, for which she paid $475.[2]

11. a. The patient returned on March 26, 2001, for treatment of her face. J.H. testified that it was for the removal of the "moles" respondent had identified in the prior visit. Respondent obtained a pertinent history and physical before the surgery. Respondent again noted multiple lesions and skin conditions. His diagnoses were: "1. Multiple tumors of the face, greater than 2.5 cm. Rule out basal cell carcinoma. [¶] 2. Multiple tumors of the neck, greater than 2.5 cm., with irritation, hyperpigmentation. Rule out basal cell carcinoma. [¶] 3. Tumor of the left brow, greater than 1 cm. Rule out melanoma. [¶] 4. Multiple vascular lesions, actinic keratosis and premalignant lesions of the chest, back and shoulders, greater than 10 sq., cm, requiring laser surgery." He planned to excise the tumors of the face, neck and left brow with a complex skin repair on that day, and to perform laser destruction on the vascular lesions and actinic keratosis of the back, shoulders and chest at a later date. The patient consented to the procedure, after its risks and benefits were explained.

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[1] Initials have been used to protect the patients' privacy.

[2] Findings regarding this patient are based on the medical records and the testimonies of respondent and the patient. When in conflict, respondent's testimony has been credited over that of J.H. He presented more credible testimony, corroborated by contemporaneous records that included chart notes and billing records. In addition, J.H. lacked recollection regarding critical details, such as whether she had received Botox injections, and she presented partially inconsistent testimony.

b. In accordance with his plan, respondent excised the facial and neck lesions, using a local anesthetic, and prepared an operative report consistent with his actions. Respondent appropriately performed a complex closure of the wound on J.H.'s cheek in order to obtain better results and maintain the patient's cosmetic appearance.

c. Respondent also recommended creams to treat the face, which the patient purchased for $232.

12. Respondent submitted skin specimens to a pathologist for analysis, and the resulting report was negative for carcinoma.

13. a. On April 2, 2001, J.H. returned to respondent's office at Madison for follow-up of the March 26, 2001 surgery and for laser treatment of her other lesions. The patient was doing well, and sutures were removed from her cheek.

b. Respondent discussed the risks and benefits of the procedure with the patient, and obtained her oral informed consent to the procedure. He did not have the patient sign a written consent form because the procedure was relatively minor. He had documented the discussion of a two-step plan, which included the laser procedure, on the March 26, 2001 history and physical chart note; after a discussion of the plan, respondent wrote, "The patient gives her informed consent to proceed with the necessary reconstructive surgery." The experts who testified regarding the subject, Angelo Capozzi, M.D. (Capozzi) and Melvin Shiffman, M.D. (Shiffman), called by complainant and respondent, respectively, agreed that a signed written consent form was not required for the procedure if the patient gave an informed oral consent.

c. Respondent performed the laser procedure, which he described in the operative report as "Laser destruction of multiple tumors of the chest, back and shoulders, greater than 10 sq., cm." He again used local anesthesia and did not prepare a separate anesthesia chart note. He destroyed over 22 lesions, ranging in size from 8 mm to 1.3 cm, using a "pulsed dye laser at 14 joules, 20 milliseconds, and a 7 mm spot size." Although it is alleged that respondent's failure to use a PDT (photo dynamic therapy) laser constituted a deviation from the standard of care, complainant's expert on this point, Dr. Capozzi, conceded that the standard did not require such laser and that some physicians have had success without PDT.

14. Respondent used local anesthesia for the March 26 and April 2, 2001, procedures. As required by the standard of care, respondent documented his use of the local anesthetic, but did not prepare a more complete anesthesia note. Respondent's expert, Richard Hochman, M.D. (Hochman) credibly testified, with partial corroboration by complainant's expert Dr. Capozzi, that a formal anesthesia record is not required for administration of local anesthesia for the type of procedures J.H. underwent.

15. Dr. Capozzi testified that the March 26 and April 2, 2001 procedures were not medically necessary. His testimony is unpersuasive. Dr. Capozzi's conclusions were largely based on the patient's statements regarding the nature of the lesions. Unlike respondent, Dr.

Capozzi did not examine the patient to evaluate the seriousness of the lesions. Moreover, Dr. Capozzi's direct examination testimony is partially inconsistent with that given on cross-examination. He defined "medically necessary" procedure as one that provides some benefit to the patient, and conceded on cross-examination that the removal of the pre-cancerous lesions had some prophylactic benefit for the patient.

16. J.H.'s next office visit was on May 18, 2001, for follow-up, and respondent removed a remaining suture. As was his custom, respondent wrote the billing code for the procedure on his chart note, to facilitate office staff billing. The code he wrote was "10160," or aspiration and removal of a foreign body. The computer program used by respondent's office did not have sufficient space for the entire written description and the staff dropped the words after "aspiration."

17. On August 1, 2001, J.H. sought consultation regarding lesions on her left leg. Respondent also injected Botox on J.H.'s face, for which she paid $400.

18. a. Respondent billed J.H.'s insurance for the procedures performed on March 26 and April 2, 2001. As was customary, he billed separately for his services as the surgeon and for those of the surgery center, Madison. His bill for March 26, 2001 was $2,050, and that for Madison, which included operating room usage, recovery room usage, medical supplies, and pharmacy/anesthesia supplies, was $4,125. The numbers for the April 2, 2001, procedure were $1,000 and $2,567, respectively.

b. It was not established that respondent's charges were excessive, unreasonable, or false, given the procedures performed and the costs to maintain the equipment and operating room.

19. J.H.'s private insurance paid $2,053.67 for the March 26, 2001 procedure, but denied payment for the April 2, 2001, purportedly as not medically necessary.

20. On January 21, 2005, after delays resulting from a number of factors, including the processing of insurance claims, the incorrect billing to J.H.'s ex-husband's address, and a change of address by J.H., the patient received a bill from respondent in the amount of $12,052.05. The largest portions of the bill stemmed from the March 26 and April 2, 2001 procedures, and included $3,103.72 in interest charges. Respondent and J.H. were unable to reach a satisfactory accommodation regarding the bill, and J.H. filed a complaint with the Board.

Patient J.M.

21. The patient, a woman born on September 26, 1964, had seen respondent for hair removal in 2001 or 2002.

22. a. J.M. presented on February 6, 2004, seeking fuller lips. Respondent explained the options of Bellergan and Dermalogen fat injections, together with each one's costs, benefits, and risks. The risks of Bellergan discussed included bumps, irregularities, bleeding, and fat reabsorbtion, and respondent documented the discussion.

b. J.M. gave her oral consent to the fat injections, and opted to try both to see if she would like the results.

c. Respondent proceeded to inject one cubic centimeter (cc) of Bellergan in J.M.'s upper lip and one-half cc of Dermalogen in the lower lip.

23. a. The patient underwent another procedure on March 1, 2004. Respondent and Dr. Decunto removed fat from J.M.'s abdomen and injected it in her lips, 4.5 cc in the upper lip and 2.5 cc in the lower lip.

b. Respondent explained the risks of the procedure and obtained the patient's written informed consent. J.M. signed a "Consent Form for Surgery," authorizing Dr. Decunto to perform "fat grafts to face and lips." She also signed a separate form indicating that "The following risks and side effects, among others, have been specifically made clear to me: 1. Temporary bruising, swelling and numbness; 2. Probably will need to be repeated; 3. Asymmetry; 4. Local infection; 5. May not be permanent; 6. Irregularity and contouring deficiency; 7. Need to repeat procedure."

c. Respondent used local anesthesia for the surgery, and charted its use in accordance with the standard of care

d. Surgery commenced at 2:30 p.m. and concluded one hour later. Respondent did not prepare an operative report, instead noting pertinent facts in a brief progress note. Respondent's failure to prepare an operative report constitutes a deviation from the standard of care.

Patient A.B.

24. The patient, a 29-year-old woman, first presented to respondent's office on March 11, 2004, inquiring about various cosmetic procedures. She had undergone prior surgery and wanted to improve the appearance of a scar in her abdomen from a prior surgery. She also wanted to reduce fat deposits in her abdomen, arms, back, sides, and thighs. The patient completed a brief medical history questionnaire, which disclosed her prior surgeries as "tummy tuck, liposuction, breast lift/aug[mentation]." Respondent performed a brief physical examination, suggested a lipectomy, and discussed the risks, benefits, and out-of-pocket costs of the procedure. Respondent also treated the scar with a pulsed dye laser.

25. On March 13, 2004, A.B. spoke to respondent by telephone and, after additional discussion of the risks and benefits of the procedure, agreed to undergo surgery. Respondent provided preoperative instructions, including the start of vitamins and minerals.

26. a. A.B. did not present any history of pulmonary disease, diabetes mellitus, hypertension, or coronary artery disease. She was five-feet, six-inches tall and weighed approximately 190 pounds.

b. Respondent obtained laboratory results from Methodist Hospital of Southern California, which results were based on blood collected on December 13, 2003. The results of the comprehensive metabolic, complete blood count, and differential panels were normal, with the exception of a slightly elevated glucose level and a slightly low bicarbonate level.

c. Complainant called Michael C. Ciano, M.D. (Ciano) as an expert witness. Dr. Ciano has been a practicing plastic surgeon in Los Angeles since 1982, and has performed many liposuction procedures. He holds a certification from the American Board of Plastic Surgeons and has held a clinical teaching position with the University of California, Los Angeles, School of Medicine. In his opinion, the standard of care required more recent blood analysis laboratory results because liposuction involves substantial blood loss and because the patient was a menstruating woman. On the other side, Dr. Hochman, who has similar experience and qualifications, testified that surgeons, in this case Dr. Decunto, have discretion regarding how recent laboratory reports to rely on. In Dr. Hochman's opinion, it was not outside the standard of care for Dr. Decunto to have used three-month-old laboratory results from a healthy young woman for a liposuction procedure that does not involve significant blood loss. In light of Dr. Hochman's well-reasoned opinion, complainant has not established a deviation from the standard of care by clear and convincing evidence.

27. The patient presented for surgery on March 26, 2004. Respondent had planned to provide anesthesia and Dr. Decunto was to be the surgeon. Respondent did not intend to provide general anesthesia, but planned to provide what he referred to as "conscious sedation," a state where the patient, although sedated, remains able to respond to verbal or physical stimuli. Dr. Hochman referred to it as "light general anesthesia," and noted surgeons refer to the state as "twilight sleep."

28. At approximately 5:20 a.m., respondent and Dr. Decundo discussed the risks of the procedure with A.B. and provided her with consent forms. One document was entitled "Suction Assisted Lipectomy (SAL) Information Sheet." Two forms listed the risks of lipoplasty and fat grafting, respectively. The lipoplasty form stated, "The following risks and side effects, among others, have been specifically made clear to me:", and listed: death; disfigurement; asymmetry; nerve injury; unsatisfactory scarring; infection; need for secondary procedures, possibly skin excision; contouring irregularities; changes in skin color; swelling – persistent edema; tape reaction or tape burns; collection of fluid –seroma, hematoma; skin breakdown; fat embolism; shock; in patients over the age of 40, increased risk of redundant skin and lumpiness. A "Consent Form for Surgery" authorized Dr. Decunto to perform "liposuction back, flanks, arms, axilla and abdomen, release suprapubic contracture with fat graphs, possible tissue rearrangement, suprapubic area, possible fat gra[fts] right arm." The patient signed the forms.

29. An intravenous line (IV) was started at approximately 5:30 a.m., while the patient was in the recovery room. A.B. started receiving intravenous saline fluids at 5:30 a.m. Preoperative antibiotics were administered at 5:30 and 5:40 a.m. However, A.B. had second thoughts about proceeding with surgery, and, at approximately 5:45 a.m., surgery was stopped.

30. Respondent called A.B.'s husband for him to pick her up. A.B.'s husband came to Madison, and spoke to the patient. They later spoke to Dr. Decunto, who assured them that he had successfully performed similar procedures in the past. After these discussions, the patient decided to proceed with surgery, but asked for something to calm her down. At 6:30 a.m., Dr. Decunto administered 5 milligrams (mg) of Valium through the IV. A.B.'s husband and Dr. Decunto then accompanied A.B. back to the operating room. Respondent did not participate in the discussions, but was informed later that the patient decided to proceed with surgery.

31. Respondent and Dr. Decunto, the latter called as a witness by complainant, provided testimony regarding the events of March 26, 2004. Their testimony was generally consistent and the findings regarding events during the surgery are based on their testimony and the anesthesia record, which is also materially consistent with the physicians' testimony. Areas in which their testimony contains material differences are discussed in greater detail.

32. Respondent prepared the anesthesia record, a one-page contemporaneous chart note containing timed entries of vital signs, drugs used, and other pertinent information. However, respondent failed to enter the following information, as required by the standard of care: the patient's level of consciousness, at 15-minute intervals; the patient's temperature; and, an indication that electrocardiogram (ECG) monitoring was employed. Once Propofol was administered, the standard of care required charting of vital signs at least every five minutes; respondent's entries between 7:22 and 8:26 a.m. were recorded at six-minute (once), eight-minute (once), or ten-minute (four) intervals.[3]

33. The patient was placed in the prone position on the operating table. An airway tool, described by respondent as a "bent shoe horn" and in the largest size used for female patients, was placed in A.B.'s mouth to keep the airway open and to keep the tongue out of the way. Supplemental oxygen at the rate of four liters per minute was provided via nasal cannula from large tanks kept in the operating room.

34. Respondent's primary position was by the patient's head, seated on a stool with wheels. A counter with supplies and medications was to his left. Blood pressure, EGC, and pulse oxymeter monitors were in place and the instruments' screens were on a cart stationed on the side of the patient. The screens were to respondent's left and visible to him during the procedure. In addition to the visual information, the monitors emitted sounds. A temperature strip was placed in the patient's forehead at the start of the procedure, and showed a temperature of 98 degrees; a second strip used later in the procedure measured a temperature of 96 degrees.

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[3] This finding is based on the credible and persuasive testimony of complainant's expert, Roger F. Donenfeld (Donenfeld.)

Respondent was in a position to observe the patient's face, her skin color, and physical signs of breathing.

35. Respondent and Dr. Decunto employed two surgical technicians as assistants during the procedure, Jeanette Margolis and Gina Corcoran (Corcoran), neither of whom was trained as a registered nurse.

36. The patient appeared anxious at 6:51 a.m., and respondent provided another 10 mg of Valium. More sedation was given at 7:00 a.m., in the form of 10 mg of Valium and 25 mg of Demerol. A.B. was still anxious at 7:10 a.m., and respondent administered another 10 mg dose of Valium, this time accompanied by one-quarter ampule of Thorazine, a tranquilizer. At 7:14 a.m. respondent administered 10 mg of Propofol, a quick-acting, short-lived anesthetic, and another 5 mg of Valium, to commence the procedure. The tumescent solution, containing four liters of tumescent fluid, 24 cc of 2 percent lidocaine and 2 cc of epinephrine, was also administered at 7:14 a.m. Respondent induced subsequent 10 mg doses of Propofol at 7:22, 7:30, 7:50, and 8:10 a.m., or a total of 50 mg (5 cc). Respondent alternated the Propofol with another short-acting anesthetic, ketamine, which was applied in three 25 mg doses, at 7:17, 7:40, and 8:00 a.m., and which was accompanied by Demerol, 25 mg, 12.5 mg, and 12.5 mg, respectively.

37. The chart does not record the order in which the surgery proceeded, but respondent presented testimony based on his recollection and the typical progression of similar procedures. Thus, the flanks were done first, each taking approximately 10 minutes; the saddles were next, each at 3-5 minutes; the posterior back and the thighs followed; and the arms and axilla were done after those areas.

38. Respondent testified that he assisted Dr. Decunto by performing the liposuction of the inner thighs, a task that took him about three to four minutes, or one-and-one-half to two minutes for each thigh, starting at approximately 7:41 or 7:42 a.m. Respondent stated that he performed the liposuction from his station by the head of the patient by reaching toward her thighs, and that he was able to continue to monitor the patient while engaged in the procedure; the monitors were still in his line of sight and his head was actually closer to the patient's head, enabling him to hear her breathing. Respondent also noted that the inner-thigh fat is one of the easiest to aspirate, not as physically demanding on the surgeon as other areas.[4]

39. Dr. Decunto testified that respondent suctioned the interior thigh areas. He stated that respondent moved from the area near the head of the patient closer to her thighs. Dr. Decunto estimates that it took respondent about 10 minutes to complete work on both thighs. He does not recall what respondent did next. Of critical importance, however, Dr. Decunto did not recall where respondent was or how much time had passed between the time respondent performed liposuction on the thighs and the time the patient experienced difficulty breathing, as set forth below; this lack of recollection shows, consistent with respondent's testimony, that a

[4] Respondent has ceased performing more physically demanding surgical procedures because of limitations resulting from neck injuries.

significant period of time had passed between the two events. Thus, despite the critical differences between the testimonies of the two physicians regarding respondent's location and length of assistance, the testimony is consistent in that respondent's involvement in surgery did not occur close in time to the patient's condition becoming critical.

40. Respondent testified that he was able to continuously monitor the patient's condition and that he charted her vital signs at pertinent intervals. As of 8:20 a.m., her breathing, color, and vital signs were at acceptable levels. She was responsive to stimuli, but was not screaming in pain.

41. Respondent testified that he continued to monitor the patient after 8:20 a.m. At 8:26 a.m., both respondent and Dr. Decunto heard the pulse oxymeter alarm. The monitor showed an abnormally low reading of 60. Respondent checked that the pulse oxymeter lead was still in place in the patient's finger. When he confirmed placement, he directed one of the assistants, Corcoran, to bring another pulse oxymeter machine from the recovery room. Less than two minutes later, at 8:28 a.m., the new pulse oxymeter was in place and it provided a still low blood oxygen saturation reading of 65. By this time, the patient's lips were turning blue, her blood pressure was dropping (70/40), and the ECG monitor was erratic.

42. While Corcoran was retrieving the new pulse oxymeter, respondent held the patient's neck back and inserted a new, larger airway tool to improve oxygenation. Dr. Decunto ceased performing surgery and started providing additional oxygen via a portable oxygen bag with a pump, or "ambu bag." This device delivered approximately eight liters per minute. Dr. Decunto and the assistant performed cardiopulmonary resuscitation, and respondent administered medication to the patient to reverse the respiratory depressant effects of Demerol and Valium. The assistant was directed to call 911, which she did. Engaged in the foregoing activities, neither respondent nor Dr. Decunto were able to intubate the patient.

43. The experts disagreed regarding the need to intubate the patient. Dr. Ciano testified that the standard of care required immediate intubation. Dr. Hochman countered that such intubation would interfere with chest compressions and that the ambu bag with the airway management underway was appropriate. In light of the disparity of opinion, each of which has its merits, complainant did not establish, by clear and convincing evidence, that the standard of care required respondent to intubate the patient prior to the arrival of the paramedics.

44. Paramedics arrived at 8:35 a.m. and took over management of the patient. A.B. was in full cardiac arrest; she did not have a pulse and was not breathing. The paramedics intubated her and performed defribulation, twice.

45. The paramedics made the decision to take A.B. to Torrance Memorial Hospital (TMH), the closest medical center with an emergency room. The patient arrived at TMH at 8:54 a.m.

46. On March 26, 2004, respondent had agreements with San Pedro Peninsula Hospital, Daniel Freeman Memorial Hospital, and Community Hospital of Gardena, local medical centers with emergency rooms in the event such was needed for a patient undergoing outpatient surgery at Madison. Having such arrangements comports with the standard of care and respondent's obligation to patients undergoing outpatient surgery at Madison.

47. On March 26, 2004, respondent did not have a transfer agreement or medical privileges at TMH. This failure does not constitute a deviation from the standard of care, as respondent did not know which medical center the paramedics would take the patient. In addition, the surgeon in the procedure, Dr. Decunto, had medical privileges at TMH and followed the patient to the hospital to provide information to emergency room personnel and follow-up care to A.B.

48. Emergency physicians at TMH continued treatment to stabilize the patient, and, employing aggressive resuscitative measures, were able to restore cardiac and pulmonary function to A.B.

49. A chest x-ray taken at 9:22 a.m. showed that the endotracheal tube had been incorrectly inserted into the pulmonary right main stem. At 10:20 a.m. the tube was withdrawn by two centimeters and placed into proper position. Having placed the tube too far into the right lung deprived the left lung of the benefits of oxygen and resulted in suboptimal oxygenation.

50. The patient was transferred to the intensive care unit at TMC, where she remained in a comatose condition. An electroencephalogram on March 28, 2004, revealed no electrical brain activity. Mechanical ventilation was withdrawn on March 30, 2004, and the patient was pronounced dead at 8:30 a.m.

51. The Los Angeles County Department of Coroner conducted an autopsy, and Louis A. Pena, M.D., concluded that the death had been accidental, the result of bronchopneumonia due to probable anoxic encephalopathy.[5]

Additional Findings Regarding Alleged Deviations from the Standard in the Care of A.B.

52. a. The standard of care requires direct and continuous monitoring of the patient, particularly her respiratory ability, by the person administering the anesthesia. As Dr. Donenfeld noted, this is particularly critical given the potential for the Propofol, in combination with the other sedatives, to send the patient into a deep sedation stage. Also, monitoring is

[5] The experts disagreed about the cause of the patient's demise. Complainant's experts, primarily Dr. Donenfeld, placed blame on respondent's failure to properly monitor the patient's vital signs. Respondent's experts, particularly Dr. Shiffman, noted that unforeseen, extraordinary complications, such as an embolism, may have caused the patient's death. Supporting Dr. Shiffman's position, the coroner did not rule out a fat embolism. However, resolution of this conflict is not necessary to evaluate respondent's actions in light of the standard of care or the potential risks of deviations from the standard.

critical because some of the drugs administered, namely, Demerol and Valium, tend to depress respiration.[6]

b. Respondent deviated from the standard of care by engaging in liposuction of the inner thighs while responsible for monitoring the sedated patient. Because he was engaged in surgery, his attention was, at best, divided between both tasks, and his monitoring was therefore suboptimal. The deviation from the standard of care is an extreme one because of the grave potential risk to the patient from such substandard monitoring.

53. It was not established that respondent used Propofol in an inappropriate dosage. As Dr. Hochman, one of the pioneers in the use of Propofol in Southern California, testified, the 50 mg administered represent a fraction of that used for general anesthesia, and was appropriate for the patient's size and condition. Moreover, as Dr. Hochman noted, the dosages were administered in a gradual manner, consistent with need and drug action.

54. a. Respondent did not have medical malpractice insurance on March 26, 2006, which failure constitutes a deviation from the standard of care. He had set aside a sum in the event he had to settle any claims.

b. In March 2004, Dr. Decunto had medical malpractice insurance.

55. On March 26, 2004, respondent's Advanced Cardiac Life Support (ACLS) certification had expired, and the failure to have a current certification constitutes a deviation from the standard of care.

56. At 9:45 a.m., on March 26, 2004, a very low rectal temperature of 92.4 degrees was obtained from the patient at TMH. Dr. Donenfeld opined that such low temperature was indicative of respondent's failure to maintain the patient's body temperature at the appropriate normal level as required by the standard of care. On direct examination, when he initially rendered his opinion, Dr. Donenfeld assumed that the temperature had been taken upon A.B.'s arrival at TMH. He did not alter his opinion on cross-examination, when presented with the actual time. However, as Dr. Hochman pointed out, a significant period of time had passed between surgery and the rectal temperature measure, the patient had undergone a significant change in condition, and she had been exposed to the outside temperature during her transfer to TMH, all of which make it difficult to reach precise conclusions regarding temperature in the operating room. Moreover, respondent testified that he measured the patient's temperature on two occasions and that it was normal in each instance. In these circumstances, the low temperature obtained at TMH is not sufficient to establish that respondent, or Dr. Decunto as the surgeon, failed to properly maintain the patient's body temperature in the operating room.

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[6] This finding is based on the testimony of Dr. Donenfeld, which was consistent with published guidelines and was only partially contradicted by that of Dr. Hochman.

57. Respondent did not notify the Board, within 15 days of A.B.'s death, of the patient's death, which failure constitutes a deviation from the standard of care.

Adequacy of Respondent's Record Keeping

58. Respondent's charts for the three patients were largely illegible, which constitutes a deviation from the standard of care. In fact, respondent himself had difficulty reading his own writing at the hearing.

Character/Skill References

59. Respondent called three character witnesses. David H. Smith, M.D., a colleague since 1991, has performed between 50 and 100 procedures with respondent. He described respondent as a skilled and caring physician. Maria Basch and Rabbi Eli Hecht applauded respondent's many charitable community services.

60. Dr. Decunto testified that respondent is a well-trained and competent physician.

Other Allegations and Arguments

61. Except as set forth in this Decision, all other allegations in the accusation and petition to revoke probation, and all other arguments by the parties, lack merit or constitute surplusage.

LEGAL CONCLUSIONS

1. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code[7] section 2234, subdivision (b), in that he engaged in gross negligence, by reason of factual finding numbers 38, 39, 40, and 52.b.

2. Cause exists to discipline respondent's certificate pursuant to section 2234, subdivision (c), in that he engaged in repeated negligent acts, by reason of factual finding numbers 23.d., 32, 54, 55, 57, and 58.

3. The established violations are insufficient to establish that respondent was incompetent in his care and treatment of any of the three patients. Therefore, cause does not exist to discipline respondent's certificate pursuant to section 2234, subdivision (d).

4. Cause exists to discipline respondent's certificate pursuant to section 2216.2, in that respondent did not maintain medical liability insurance in March 2004, by reason of factual finding number 54.

[7] All further references are to the Business and Professions Code.

5. Cause exists to discipline respondent's certificate pursuant to section 2240, in that respondent did not notify the Board of A.B.'s death in a timely manner, by reason of factual finding number 57.

6. Cause exists to discipline respondent's certificate pursuant to section 2266 in that he failed to maintain adequate and accurate records, by reason of factual finding numbers 32 and 58.

7. The violation of sections 2216.2, 2240, 2234, and 2266 set forth in legal conclusion numbers 1, 2, 4, 5, and 6, constitute violations of condition number 7 (obey all laws) of respondent's probation with the Board.

8. Except as set forth in legal conclusion numbers 1, 2, 4, 5, and 6, additional cause for discipline pursuant to sections 810 (false claims), 2234, subdivisions (a) or (b), or 2234, subdivision (e), (dishonest acts), or additional violations of probation, have not been established.

9. All evidence presented in mitigation and rehabilitation, as well as that presented in aggravation, has been considered. The established act of gross negligence is very serious, and the charting errors represent repeated violations. Respondent's certificate has been discipline twice before, and he was on probation at the time he provided care to A.B. and J.M. Accordingly, significant discipline is necessary for the protection of the public. At the same time, the purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476). On balance, the order that follows is, therefore, necessary and sufficient for the protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G 36859 issued to respondent Lawrence Saks, M.D. is hereby revoked. However, the revocation is stayed and respondent's certificate is placed on probation for seven years upon the following terms and conditions.

1. Actual Suspension. As part of probation, respondent is suspended from the practice of medicine for 240 days, beginning the sixteenth day after the effective date of this Decision.

2. Education Course. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division of Medical Quality (Division) or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be

in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Medical Record Keeping Course. Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Notification. Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision in this matter to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carriers.

5. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

6. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. Probation Unit Compliance. Respondent shall cooperate with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

9. Interview with the Division or its Designee. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

10. Residence or Practice Outside of California. In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

11. Failure to Practice Medicine – California Resident. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non- practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

12. Completion of Probation. Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

13. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances.

Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: 2/25/08

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Accusation and Petition to Revoke Probation Against: **LAWRENCE SAKS, M.D.** 3445 Pacific Coast Highway, #240 Torrance, California 90505 Physician's and Surgeon's Certificate No. G 36859 Respondent.	Case Nos: D1-1996-69949 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this First Amended Accusation and Petition to Revoke Probation solely in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On or about June 26, 1978, the Board issued Physician's and Surgeon's Certificate No. G 36859 to Lawrence Saks, M.D. (respondent). At all times relevant to the charges brought herein, respondent's Physician's and Surgeon's Certificate was in force and effect, but was also subject to conditions of probation. The Certificate will expire on September 30, 2007, unless renewed.

3. On June 25, 2001, Third Amended Accusation No. 06-96-69949, was filed in the matter entitled, *In the Matter of the Accusation Against Lawrence Saks, M.D.*

Multiple charges were alleged against respondent in the Third Amended Accusation for gross negligence, repeated negligent acts, incompetence, false insurance claims, preparation of statements as false and fraudulent claims, making of false statements in a document related to the practice of medicine, alteration of records, and failure to maintain adequate records, in violation of the Business and Professions Code, in and during his care and treatment of multiple patients. On August 12, 2003, the Board adopted the Stipulated Settlement and Disciplinary Order, with an effective date of September 11, 2003. Respondent's Physician's and Surgeon's Certificate was revoked. The revocation was stayed and respondent was placed on probation for seven (7) years with terms and conditions. Respondent's probation term began on September 11, 2003, and is set to expire on or about September 11, 2010. A copy of that decision is attached as Exhibit "A" and is incorporated by reference.

JURISDICTION

3. This First Amended Accusation and Petition to Revoke Probation is brought before the Board's Division of Medical Quality (Division) under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

5. Section 2216.2 of the Code provides:

(a) It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(b) For purposes of this section, the board shall determine what constitutes adequate security.

(c) Nothing in this section shall require an insurer admitted to transact liability insurance in this state to provide coverage to a physician and surgeon.

(d) The security required by this section shall be acceptable only if provided by any one of the following:

(1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state.

(2) An insurer that appears on the list of eligible surplus line insurers pursuant to subdivision (f) of Section 1765.1 of the Insurance Code.

(3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code.

(4) An insurer licensed to transact liability insurance in at least one state of the United States.

6.Section 2240 of the Code states, in pertinent part:

"(a) Any physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence.

"(b) Any physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours, of any patient on whom that medical procedure was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing, on a form prescribed by the board that occurrence, within 15 days after the occurrence. The form shall contain all the following information:

"(1) Name of the patient's physician in the outpatient setting.

"(2) Name of the physician with hospital privileges.

"(3) Name of the patient and patient identifying information.

"(4) Name of the hospital or emergency center where the patient was transferred.

"(5) Type of outpatient procedure being performed.

"(6) Events triggering the transfer.

"(7) Duration of the hospital stay.

"(8) Final disposition or status, if not released from the hospital, of the patient.

"(9) Physician's practice specialty and ABMS certification, if applicable.

"(c) The form described in subdivision (b) shall be constructed in a format to enable the physician and surgeon to transmit the information in paragraphs (5) to (9),

inclusive, to the board in a manner that the physician and surgeon and the patient are anonymous and their identifying information is not transmitted to the board. The entire form containing information described in paragraphs (1) to (9), inclusive, shall be placed in the patient's medical record.

. . . .

"(f) The failure to comply with this section constitutes unprofessional conduct."

7.Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8.Section 810 of the Code states:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim."

INTRODUCTION

RESPONDENT LAWRENCE SAKS, M.D.

9. At all times relevant to the allegations contained herein, respondent has been, and is now, a plastic surgeon who owns and operates Madison Park Surgery Center and Laser Center, DHS Certification number 05C0001361, an unaccredited outpatient surgery center (Madison Park or surgical center). Madison Park is located at 3445 Pacific Coast Highway, Suite 240, Torrance, California.

10. Respondent's practice is also known as Reconstructive Surgery Associates, at the same address and phone number as Madison Park.

11. In March 2004, respondent did not maintain any liability insurance. Respondent also did not have admitting privileges or transfer agreements with any local acute care hospital.

MARIO DECUNTO, M.D.

12. At all times relevant to the allegations contained herein, Mario Decunto, M.D., has been, and is now, a board certified obstetrician and gynecologist.

13. Dr. Decunto maintains an office at 4055 E. Whittier Blvd., Los Angeles, California.

14. Dr. Decunto began working with respondent in 1982, using respondent's facility for gynecological procedures.

15. In September 2003, Dr. Decunto began performing plastic surgery with respondent; he began training under respondent performing liposuctions. Dr. Decunto also performs breast augmentations and abdominoplasties. During that time frame, respondent was suspended from the practice of medicine from October 2003 through January 2004.

16. During March 2004, Dr. Decunto was either an employee of respondent and received a salary or was an independent contractor, compensated by respondent's medical practice for (plastic) surgical procedures performed at respondent's facility.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of patients. The circumstances are as follows:

Factual Allegations re Patient Anel B.

18. On or about March 11, 2004, patient Anel B. was a 29 year-old female who consulted with respondent at Madison Park for elective plastic surgery. At the initial consultation, respondent also evaluated the patient for future surgical operations as well as evaluated the patient for laser treatment for a hypertrophic scar of the abdomen from a previous surgery. Respondent performed laser treatment on the patient's initial visit, without any further

documentation. Respondent, however, did not conduct a physical examination of the patient during the initial visit, or failed to document the results of a physical examination. Respondent also failed to take or record the patient's height, weight or other vital signs. A copy of the patient's laboratory blood levels (hemoglobin and hematocrit) from Methodist Hospital of Southern California, drawn three months prior on December 13, 2003, was in the patient's records. Otherwise, respondent failed to obtain or request recent blood work in preparation for the patient's planned elective surgery.

19. On or about March 13, 2004, respondent telephoned the patient to discuss the procedures planned: a suction assisted lipectomy of the trunk, probable fat grafts to the upper arms and removal of pubic fatty tissue.

20. On or about March 26, 2004, patient Anel B.'s husband brought the patient to the surgery center at approximately 5:10 a.m., for her elective surgery. The patient was to have liposuction performed by respondent, and Dr. Decunto was to administer the anesthesia. Dr. Decunto, however, performed a history and physical of the patient on the morning of surgery. The patient's husband noted that no one else was at the surgery center except respondent and Dr. Decunto. He left his wife with the doctors and left the center.

21. Respondent marked the patient for surgery in the recovery room while she was in a naked, standing position, and began the patient on an IV. The patient was given Valium by Dr. Decunto to calm her. The patient signed various consent forms with Dr. Decunto, and respondent witnessed the forms. The forms authorized Dr. Decunto, not respondent, "to perform the following plastic and/or reconstructive surgical operation(s): liposuction back, flanks, arms, axilla and abdomen, release suprapubic contracture with fat graphs, possible tissue rearrangement, suprapubic area, possible fat graphs right arm." The patient, however, only wanted to have liposuction performed.

22. The anesthesia record shows that the patient was given 1 gram of Ancef at 5:30 a.m., 80 mg. of Gentamicin (antibiotic) at 5:50 a.m., and .5 cc of droperiodol (Inapsine) for sedation at 5:42 a.m. The patient then crawled onto the operating table, in a prone position. However, the patient began to get nervous and did not feel comfortable about having the surgery.

She expressed that she was not feeling well and that she wanted to call her husband. The patient was then taken to the recovery room where she called her husband.

23. The patient's husband received a call from patient Anel B. asking him to pick her up and to remove her from the clinic. She told him that she was examined in the nude while standing up. She did not feel comfortable and wanted to leave.

24. When her husband arrived at the surgical center, he found the patient holding her body and murmuring that she was cold. She was hysterical and had dry foam at the corners of her mouth. The patient's husband observed that Anel B. only had on a paper and cloth hospital gown that covered her upper torso. The patient's husband observed respondent inject a substance into his wife's IV line while in the operating room. Dr. Decunto told the patient's husband that the medication dries secretions and body fluids, and would slow down any fluids that might secrete from the patient's body after the procedure was completed. Dr. Decunto spoke with the patient's husband and informed him that his wife's reaction was common. Dr. Decunto told the patient's husband that his wife's uneasy feeling was probably caused by the medication she had been given. The patient's husband asked respondent whether his wife's reluctance was a common occurrence. Respondent replied, "No, this is one in a million," and left the room.

25. The patient's husband, however, continued to make inquiries about the situation with Dr. Decunto. Again, Dr. Decunto said that the patient's reluctance to continue with the procedure was common and that he had encountered many women, at the "naval base," that were initially reluctant only to proceed with the procedure at a later date. The patient's husband asked the patient if she was concerned because there was no female present and the patient responded affirmatively. At that point, Dr. Decunto left the room and the patient's husband thought Dr. Decunto left to contact or locate a female staff. Dr. Decunto returned a short while later, however, without any other staff member. The patient was then escorted to the operating table The patient again crawled onto the operating table, lay face down in a prone position, with her head turned to the right. The patient was on the operating room table naked, without any warming lamps or sterile covers. Dr. Decunto said he would give the patient something to relax the patient; he then injected 5 mg of Valium into the patient's IV line. The

patient's husband noticed that his wife's heart rate was between 125-128 bpm prior to the injection and in the mid-90's after the injection. The patient told the husband that she was cold and within a matter of minutes the patient appeared to be asleep. He called out her name, but did not receive any response.

26. The patient's husband then observed Dr. Decunto place a heart monitor device on the patient's finger and an oxygen tube in her nostril. Dr. Decunto escorted the patient's husband to the door of the operating room. No one else was in the operating room except Dr. Decunto and the patient. Outside the operating room, respondent assured the patient's husband that the operation would be a success. The patient's husband then went to work.

27. The Intra-Operative Record & Op Note (Op Note) noted that anesthesia began at approximately 6:50 a.m. Surgery began at approximately 7:13 a.m., and ended at 8:28 a.m. Dr. Decunto was listed as the surgeon and respondent was listed as the anesthesiologist. Respondent noted Jennette Margolis, an unlicensed individual, as the circulating/scrub nurse. The patient received 10 mgs. of Valium at approximately 6:51 a.m. At 7:00 a.m., she received an additional 10 mg. of Valium and 25 mg. of Demerol. At 7:10 a.m., the patient received another 10 mg. of Valium and a quarter cc of Thorazine 6.25. At 7:14 a.m., the patient was given 5 mg. of Valium. and 10 mg. (1cc) of Propofol. There is no indication in the medical record that the patient was switched to an oral airway at this time. At 7:17 a.m., the patient received 25 mg. of ketamine with a half cc and 25 mg. of Demerol (which is a quarter cc). At 7:22 a.m., and again 7:30 a.m., the patient received 10 mg. of Propofol.

28. Sometime during the surgery, respondent left the head of the operating table to assist Dr. Decunto and show Dr. Decunto how to remove fat from the posterior inner thighs using wall suction. A regular wall suction machine uses low volume suction for taking fat to utilize in fact injections. The operate note reflects that 400 cc's of fat were taken from each side. Thereafter, respondent did not return to the head of the operating table to monitor the patient as an anesthesiologist.

29. At 7:40 a.m., the patient received 25 mg. of ketamine and 12.5 mg. of

Demerol. At 7:50 a.m., and again at 8:10 a.m., the patient received additional Propofol. Between these intravenous (IV) pushes, she received 25 mg. of Ketamine and 12.5 mg. of Demerol at 8:00 a.m.

30. At approximately 8:26 a.m., or 8:28 a.m., the patient desaturated. Respondent changed the oxygen saturation monitor, but it still read in the low 60's. Respondent and Dr. Decunto stopped the surgery and turned the patient over onto her back. A code was called, 911 was called and they started cardiopulmonary resuscitation (CPR). According to respondent, Narcan and Romazicon were administered to the patient with no response.

31. A Firefighter/Paramedic for the Torrance Fire Department Engine-92 responded within three minutes of the dispatch (or at approximately 8:32 a.m) Paramedics from the same department's Rescue-94 quickly followed. Upon arrival, the patient was found lying on her back, completely nude and exposed. The patient had no pulse and was not breathing. She was in full arrest. Her pupils were fixed and dilated, which indicates her brain had been without blood or oxygen for some period of time. The paramedic looked for airway management devices but did not see any in the room. There was no crash cart, no electrocardiogram machine (ECG), no oxygen tank, and the patient had not been intubated. Also, no heating lamps or other warming equipment were on site. The paramedic took over the airway management and intubated the patient. The paramedics observed that the other individuals in the room were not correctly managing the patient's airway with the Ambu-bag. The Ambu-bag was being squeezed each time the doctor was doing a compression which was too fast and prevented air to the patient. A paramedic used the fire department's own equipment, intubated the patient, and hooked up the department's Ambu-bag with a line to an oxygen tank. One of the paramedics tried to get information regarding the circumstances of the arrest, the patient's medical history, medications and allergies. However, no information was provided to the paramedic other than Dr. Decunto stating that "she is a healthy young female." Also, no medical records were provided to the paramedics. The patient was then hooked up to an ECG machine. The patient was in ventricular fibrillation (V-fib) such that the ventricles of the heart were not contracting and the rhythm was not sustaining the patient's life. An IV line was started. The paramedic asked one of the doctors

whether the patient was given any medications for the arrest and received a "no" in response. The patient was then moved from the operating table to a hard backboard to continue the patient's airway management en route to the hospital. The oxygen line got tangled on the gurney and the paramedic asked Dr. Decunto to cut the oxygen line. Instead, respondent cut the IV line, which was noticed immediately and replaced.

32. At approximately 8:40 a.m., the patient's husband received a telephone call from respondent stating that patient Anel B. had gone into cardiac arrest and was being transported to the hospital by EMT's.

33. Resuscitative measures continued en route to the hospital. The patient regained pulses at approximately 9:14 a.m., but continued to deteriorate. At Torrance Memorial, the patient was admitted with a rectal temperature of 92.4, and in critical condition.

34. The patient's husband rushed to the hospital. Shortly after his arrival, Dr. Decunto arrived and told the patient's husband that he noticed the patient's vital signs dropping and that he saw that she had turned blue. Dr. Decunto said that respondent gave the patient medication to counteract the anesthesia Dr. Decunto told the patient's husband that respondent was the surgeon and the anesthesiologist. Dr. Decunto also denied giving the patient any medication during the procedure although the patient's husband had observed Dr. Decunto injecting medication in the patient's IV line.

35. Patient Anel B. remained comatose at Torrance Memorial Hospital until she died on or about March 30, 2004.

36. Respondent failed to notify the Medical Board of California that the patient was transferred to a hospital from an out-patient-surgery center and that a death resulted.

37. On or about April 1, 2004, the Los Angeles County Coroner's Office reported to the California Medical Board that patient Anel B. died during a liposuction procedure performed at Madison Park.

38. On or about April 2, 2004, an autopsy was performed by the coroner who concluded that the cause was accidental death based upon findings of bronchopneumonia secondary to anoxic encephalopathy status post cardiac arrest. Specifically, the cause of death

was brain death from lack of oxygen, a completely preventable death. Additional findings from the coroner's report included volume expansion of the circulatory system, hypothermia or loss of body temperature to critical levels, and hypoventilation or insufficient breathing due to the patient's obesity and prone positioning. The coroner's report included consultations from an anesthesiologist who noted, "the death is the consequence of a poorly-monitored and poorly-understood physiologic and pharmacologic issues and extensive liposuction surgery with volume expansion, dilation, hypothermia to critical cardiac levels, hypoventialtion due to prone positioning and obesity, acute blood loss and possible acute overdoes of Lidocaine and epinephrine."

39. The coroner's report did not reveal evidence of fat emboli which are a known complication of liposuction resulting in the loss of oxygen from fat particles thrown to the lungs, another unforeseen, known complication of this procedure.

Allegations of Gross Negligence re Patient Anel B.

40. The following acts and omissions of respondent during his care, treatment, and management of patient Anel B., considered singularly or collectively constitute an extreme departures from the standard of practice:

41. Between on or about March 11, 2004, and March 26, 2004, respondent was grossly negligent when he failed to obtain prior to the planned elective surgery pertinent preoperative laboratory studies such as recent hemoglobin or hematocrit levels.

42. On or about March 26, 2004, respondent was grossly negligent when he failed to have admitting privileges or transfer agreements with the local acute care hospital from his outpatient surgery center in violation of section 1248.15 of the Health and Safety Code.

43. On or about March 26, 2004, respondent was grossly negligent when he failed to have any medical malpractice insurance covering himself or the surgery center.

44. On or about March 26, 2004, respondent was grossly negligent in his use of medications, in combination and dosages, prior to and/or during the procedure.

45. On or about March 26, 2004, respondent was grossly negligent when he administered propofol anesthesia or deep anesthesia to patient Anel B. without having the proper

training and privileges to do so.

46. On or about March 26, 2004, respondent was grossly negligent when he failed to utilized proper surgical instruments in the course of liposuction. Specifically, wall suction was used in the inner thigh area.

47. On or about March 26, 2004, respondent was grossly negligent when he failed to properly maintain the patient's body temperature or allowed the patient's body temperature to decrease during the procedure which increased the likelihood of hypothermia.

48. On or about March 26, 2004, respondent was grossly negligent when he simultaneously participated as both the assistant or primary surgeon and as the anesthesiologist during patient Anel B.'s surgical procedure.

49. On or about March 26, 2004, respondent was grossly negligent when he failed to continually assess the patient's level of consciousness and cardiac and respiratory effects during sedation.

50. On or about March 26, 2004, respondent was grossly negligent when he failed to continually monitor and record EKG, respiratory rate, oxygen administration, and route of administration during sedation.

51. On or about March 26, 2004, respondent was grossly negligent when he failed to monitor patient Anel B.'s respiratory rate every 5 minutes during the procedure.

52. On or about March 26, 2004, respondent was grossly negligent when he failed to utilize a scrub nurse or technician during liposuction thereby increasing the likelihood of usage of non-sterile tools.

53. On or about March 26, 2004, respondent was grossly negligent when he permitted performance of liposuction on patient Anel B. in the prone position without intubation.

54. On or about March 26, 2004, respondent was grossly negligent when he failed to ensure the availability of a crash cart to render emergency or life preserving functions during the procedure on patient Anel B.

55. On or about March 26, 2004, respondent was grossly negligent when he failed to intubate the patient after she coded.

56. On or about March 26, 2004, respondent was grossly negligent when he failed to maintain recent advanced cardiac life support (ACLS) certification.

57. In or around April 2004, respondent was grossly negligent when within 15 days of the occurrence he either failed to report to the Board that he had performed a medical procedure outside an acute care hospital that resulted in the death of a patient, or he failed to report to the Board the transfer of a patient after a procedure performed outside an acute care hospital to a hospital or emergency center for medical treatment that lasted more than 24 hours.

Factual Allegations re Patient L.H.

58. On or about March 2, 2001, patient J.H. presented to respondent to discuss possible plastic surgery, including a face lift. Respondent suggested that moles and lesions on the patient's face, neck and shoulders be removed to make her look better. Patient J.H. agreed to have the procedures done, but only if they were covered by her insurance. Respondent's notes for this date are partially illegible. An undated photo of the patient's face and neck is in the chart. A note appears on the chart stating, "mole removal, ½ hour, for 3/26/01," with CPT code 13132 (complex surgical closing) noted. At the bottom of the page was written rule out basal cell carcinoma. The patient was billed $250.00 for the visit.

59. On or about March 3, 2001, patient J.H. saw respondent but the notes in the chart are illegible. On the bottom right hand corner is noted, "mole removal, ½ hour, book for 3/26/01." There is no mention of basal cell carcinoma. An office memo indicated that 80% of the patient's costs would be covered with a maximum out of pocket cost of $1000.00. The patient signed an arbitration agreement.

60. On or about March 26, 2001, respondent took a history from patient J.H. and performed a physical examination. He noted in the chart that the patient was concerned about basal cell carcinoma and about pigmented lesions on her back, chest and shoulders. The chart referenced multiple elevated pigmented lesions of the right nasolabial fold, right cheek, right mandibular border, right chin and left cheek. The lesions were noted to measure 4 mm by 1.2 cm in greatest dimension. There was no indication the lesions were individually examined and measured. Examination of the neck showed multiple pigmented lesions of the right, central

and left neck; with hyperemic borders, irregular pigmentation and elevation, the "total mass" of the "tumors" was greater than 2.5 cm. Examination of the left eyebrow and eyelid showed a 1.5 by 0.8 cm mass with elevation and areas of hyperpigmentation. The skin exam of the chest, back and shoulders showed multiple actinic and vascular lesions, of which respondent counted 22 with a total surface area greater than 10 cm^2. Respondent noted he wanted to rule out basal cell carcinoma of the face and neck and melanoma of the eyebrow. The plan was to excise "tumors" of the face, neck and left eyebrow with complex skin closure. Laser would be performed later. Respondent noted that he had explained possible complications and that the patient had given her informed consent to go ahead with the surgery.

61. On or about March 26, 2001, respondent excised lesions of the face and neck from patient J.H.; none of the excisions required complex closures. The chart does not contain a complete operative report. The pathology requisition form listed three specimens (face 2.5 cm, left brow 1cm, neck 2.5 cm) but did not specify the specific anatomic location nor that the pathologist should rule out basal cell carcinoma or melanoma. There was no indications of how many total specimens were provided from each site. The pathological diagnoses came back for the face as "benign intradermal nevi," for the left brow as "benign intradermal nevus" and for the neck as "multiple benign intradermal nevi and seborrheic keratosis." The size of the specimens submitted, even taking into account shrinkage, did not comport with respondent's clinical measurements.

62. On or about December 22, 2002, respondent billed an insurance carrier for complex closures using the sum of the lengths for the closures and CPT codes 13132, 13132 and 13151 for the three procedures performed on March 26, 2001. There were no billing modifiers for multiple lesions or reduced services. The total bill was $6,860.00. The patient was billed $800.00 for the first two excisions and $450.00 for the third. A pathology charge of $145.00 was made for each of the three specimens submitted. The operating room charge was $1,990.00 for the procedures. There was a $750.00 recovery room charge although there was no indication that anesthesia was used. Patient J.H. was charged $997.00 for medical supplies, $250.00 for a surgical tray and $138.00 for pharmacy/anesthesia supplies.

63. On or about April 2, 2001, patient L.H. had the lesions on her shoulders, back and chest treated with a pulse dye laser. The operative note stated that laser destruction of multiple vascular lesions, actinic keratosis and premalignant lesions from severe actinic degeneration of the chest, back and shoulders was performed. No Photo Dynamic Therapy (PDT) was performed. A pulse dye laser is indicated for vascular lesions which are always considered cosmetic; it is not indicated for use on actinic lesions or premalignant lesions unless combined with PDT, which does not require an operation. No anesthesia record was maintained in the chart which also lacked an informed consent from patient J.H.

64. Respondent billed $3,692.00 for the April 2, 2001, procedure. This included $125.00 for a comprehensive exam even though the patient had a complex consultation with a history and physical five days earlier. The laser destruction was $1,000.00, the operating room was billed at $1,1125.00, laser equipment at $710.00, laser supplies at $419.00, pharmacy/anesthesia at $138.00

65. On or about May 18, 2001, patient L.H. was seen by respondent for two aspirations. The chart does not note what was aspirated nor why.

66. On or about August 1, 2001, patient L.H. was seen by respondent. The chart notes are illegible and the reason for the visit cannot be determined.

67. Respondent received $2,188.67 from the insurance carrier yet continued to demand full payment from patient L.H.

Allegation of Gross Negligence re Patient L.H.

68. Between on or about March 3, 2001, and August 1, 2001, respondent was grossly negligent in the care and treatment of patient L.H. by reason of the following:

(1) Failing to maintain an anesthesia record for the March 26, 2001, operation on patient L.H.

(2) Failing to maintain an anesthesia record for the April 2, 2001, operation on patient L.H.

(3) Failing to obtain written, informed consent from patient L.H. for the April 2, 2001, operation on patient L.H.

(4) Treating patient L.H.'s actinic keratoses on or about April 2, 2001, with a pulse dye laser without PDT.

(5) Excessive and inappropriate billing for the March 26, 2001, and April 2, 2001, operative procedures on patient L.H.

(6) Failing to properly document the basis for the two aspirations of patient L.H. on or about May 18, 2001.

(7) Failing to document the basis for the office visit of patient L.H. on or about August 1, 2001.

(8) Failing to maintain legible progress notes in the medical records of patient L.H.

Factual Allegations re Patient J.M.

69. On or about February 6, 2004, patient J.M. presented to respondent's office where she was initially seen by Dr. Decunto. She then saw respondent, seeking larger lips. Respondent injected Bellergan-F into the patient's upper lip and Dermalogen into her lower lip. The purpose of the injections was for the patient to see what her lips could look like. Patient J.M. did not sign a consent for the injections. He charged her $400.00 the injections.

70. On or about March 1, 2004, patient J.M. saw respondent for further augmentation of her lips. The patient signed a basic consent form but the record does not reflect that respondent discussed the risks and alternatives of the treatment with the patient. Respondent aspirated 10 cc of fat from the patient's pari umbilical area and injected 3.5 cc of fat into each nasolabial fold, 2.5 cc into the lower lip and 4.5 cc into her upper lip. Respondent advised the patient that the effects of the procedure would last two to fourteen weeks. There is an anesthesia record which incorrectly lists Dr. Decunto as the surgeon. Respondent did not have malpractice insurance but Dr. Decunto did. The chart does not reflect the type of anesthesia used nor the medications given to the patient. The chart does not contain an operative report detailing what was done and how it was done.

Allegation of Gross Negligence re Patient J.M.

71. Between on or about February 6, 2004, and March 1, 2004, respondent

was grossly negligent in the care and treatment of patient J.M. by reason of the following:

(1) Failing to obtain written, informed consent from patient J.M. for the injections of Bellergan-F and Dermalogen on or about February 6, 2004.

(2) Failing to obtain an adequate informed consent from patient J.M. for the fat aspiration and injections on March 1, 2004.

(3) Failing to document an operative report for the fat aspiration from and injections for patient J.M. on March 1, 2004.

(4) Failing to maintain an accurate and adequate anesthesia record for the fat aspiration from and injections for patient J.M. on March 1, 2004.

(5) Failing to maintain malpractice insurance at the time of the February 6, 2004, and March 1, 2004, procedures on patient J.M.

(6) Failing to maintain legible progress notes in the medical records of patient J.M.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

72. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he engaged in repeated negligent acts in his care and treatment of patients. The circumstances are as follows:

Factual Allegations re Patient Anel B.

73. The facts and circumstances alleged in paragraphs 18 through 39 above are alleged here as if fully set forth.

Allegations of Repeated Negligent Acts re Patient Anel B.

74. Between on or about March 11, 2004, and March 26, 2004, respondent was negligent when he failed to obtain prior to the planned elective surgery pertinent preoperative laboratory studies such as recent hemoglobin or hematocrit levels.

75. On or about March 26, 2004, respondent was negligent when he failed to have admitting privileges or transfer agreements with the local acute care hospital from his outpatient surgery center in violation of section 1248.15 of the Health and Safety Code.

76. On or about March 26, 2004, respondent was negligent when he failed to have any medical malpractice insurance covering himself or the surgery center.

77. On or about March 26, 2004, respondent was negligent in his use of medications, in combination and dosages, prior to and/or during the procedure.

78. On or about March 26, 2004, respondent was negligent when he administer Propofol anesthesia or deep anesthesia to patient Anel B. without having the proper training and privileges to do so.

79. On or about March 26, 2004, respondent was negligent when he failed to utilized proper surgical instruments in the course of liposuction. Specifically, wall suction was used in the inner thigh area.

80. On or about March 26, 2004, respondent was negligent when he failed to properly maintain the patient's body temperature or allowed the patient's body temperature to decrease during the procedure which increased the likelihood of hypothermia.

81. On or about March 26, 2004, respondent was negligent when he simultaneously participated as both the assistant or primary surgeon and as the anesthesiologist during patient Anel B.'s surgical procedure.

82. On or about March 26, 2004, respondent was negligent when he failed to continually assess the patient's level of consciousness and cardiac and respiratory effects during sedation.

83. On or about March 26, 2004, respondent was negligent when he failed to continually monitor and record EKG, respiratory rate, oxygen administration, and route of administration during sedation.

84. On or about March 26, 2004, respondent was negligent when he failed to monitor patient Anel B.'s respiratory rate every 5 minutes during the procedure.

85. On or about March 26, 2004, respondent was negligent when he failed to utilize a scrub nurse or technician during liposuction thereby increasing the likelihood of usage of non-sterile tools.

86. On or about March 26, 2004, respondent was negligent when he permitted

performance of liposuction on patient Anel B. in the prone position without intubation.

87. On or about March 26, 2004, respondent was negligent when he failed to ensure the availability of a crash cart to render emergency or life preserving functions during the procedure on patient Anel B.

88. On or about March 26, 2004, respondent was negligent when he failed to intubate the patient after she coded.

89. On or about March 26, 2004, respondent was negligent when he failed to maintain recent advanced cardiac life support (ACLS) certification.

90. In or around April 2004, respondent was negligent when within 15 days of the occurrence he either failed to report to the Board that he had performed a medical procedure outside an acute care hospital that resulted in the death of a patient, or he failed to report to the Board the transfer of a patient after a procedure performed outside an acute care hospital to a hospital or emergency center for medical treatment that lasted more than 24 hours.

Factual Allegations re patient L.H.

91. The facts and circumstances alleged in paragraphs 58 through 67 above are alleged here as if fully set forth.

Allegations of Negligent Acts re patient L.H.

92. Between on or about March 26, 2001, and August 1, 2001, respondent was negligent in the care and treatment of patient L.H. by reason of the following:

(1) Failing to maintain an anesthesia record for the March 26, 2001, operation on patient L.H.

(2) Failing to maintain an anesthesia record for the April 2, 2001, operation on patient L.H.

(3) Failing to obtain written, informed consent from patient L.H. for the April 2, 2001, operation on patient L.H.

(4) Treating patient L.H.'s actinic keratoses on or about April 2, 2001, with a pulse dye laser without PDT.

(5) Excessive and inappropriate billing for the March 26, 2001, and April 2,

2001, operative procedures on patient L.H.

(6) Failing to properly document the basis for the two aspirations of patient L.H. on or about May 18, 2001.

(7) Failing to document the basis for the office visit of patient L.H. on or about August 1, 2001.

(8) Failing to maintain legible progress notes in the medical records of patient L.H.

Factual Allegations re patient J.M.

93. The facts and circumstances alleged in paragraphs 69 and 70 above are alleged here as if fully set forth.

Allegation of Gross Negligence re Patient J.M.

94. Between on or about February 6, 2004, and March 1, 2004, respondent was grossly negligent in the care and treatment of patient J.M. by reason of the following:

(1) Failing to obtain written, informed consent from patient J.M. for the injections of Bellergan-F and Dermalogen on or about February 6, 2004.

(2) Failing to obtain an adequate informed consent from patient J.M. for the fat aspiration and injections on March 1, 2004.

(3) Failing to document an operative report for the fat aspiration from and injections for patient J.M. on March 1, 2004.

(4) Failing to maintain an accurate and adequate anesthesia record for the fat aspiration from and injections for patient J.M. on March 1, 2004.

(5) Failing to maintain malpractice insurance at the time of the February 6, 2004, and March 1, 2004, procedures on patient J.M.

(6) Failing to maintain legible progress notes in the medical records of patient J.M.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

95. Respondent is subject to disciplinary action under section 2234,

subdivision (d), of the Code in that he was incompetent in his care and treatment of patient Anel B., L.H. and J.M. The circumstances are as follows:

96. The facts and circumstances alleged in paragraphs17 through 57 and 73 through 90 above are incorporated here as if fully set forth.

97. The facts and circumstances alleged in paragraphs 58 through 68 and 91 to 92 above are incorporated here as if fully set forth.

98. The facts and circumstances alleged in paragraphs 69 through 71 and 93 to 94 above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure To Maintain Liability Insurance)

99. Respondent is subject to disciplinary action under section 2216.2 of the Code in that respondent failed to provide adequate security by liability insurance or interindemnity trust during the period he cared for and treated patient Anel B. The circumstances are as follows:

100. The facts and circumstances alleged in paragraphs 18 through 39 and 69 to 70 above are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Failure To Timely Report Patient Death)

101. Respondent is subject to disciplinary action under section 2240 of the Code in that respondent failed to report the death of patient Anel B., which occurred during a medical procedure, within 15 days of the procedure. The circumstances are as follows:

102. The facts and circumstances alleged in paragraphs 18 through 39 above are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate Records)

103. Respondent is subject to disciplinary action under section 2266 of the Code in that respondent failed to maintain adequate and accurate medical records of his care and treatment of patients. The circumstances are as follows:

104. The facts and circumstances alleged in paragraphs 18 through 39 above are incorporated here as if fully set forth.

105. The facts and circumstances alleged in paragraphs 58 through 67 above are incorporated here as if fully set forth.

106. The facts and circumstances alleged in paragraphs 69 to 70 above are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(False Claims)

107. Respondent is subject to disciplinary action under section 810 of the Code in that respondent knowingly prepared, made, or subscribed writings, with intent to present or use the same, or to allow them to be presented or used in support of false or fraudulent claims and knowingly presented or caused to be presented false or fraudulent claims for the payment of a loss under a contract of insurance in connection with patient L.H. The circumstances are as follows:

108. The facts and circumstances alleged in paragraphs 58 through 67 above are incorporated here as if fully set forth.

109. On or about March 26, 2001, respondent knowingly falsely described patient L.H.'s nevi as tumors. On or about December 22, 2002, respondent knowingly presented for payment billings, based on the March 26, 2001, documentation, claiming that the masses had increased in size and pigmentation over the six months preceding surgery and that the "tumor surgery" was medically necessary and done for reconstructive purposes only.

EIGHTH CAUSE FOR DISCIPLINE

(Dishonest Acts)

110. Respondent is subject to disciplinary action under section 2234, subdivision (e), of the Code in that respondent committed acts involving dishonesty or corruption which were substantially related to the qualifications, functions, or duties of a physician and surgeon in connection with patient L.H. The circumstances are as follows:

111. The facts and circumstances alleged in paragraphs 108 to109 above are

incorporated here as if fully set forth.

CAUSE FOR REVOCATION OF PROBATION

(Failure to Obey Laws)

112. At all times after the effective date of respondent's probation, Condition 7 stated that respondent must obey all laws.

113. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 7, referenced above. The facts and circumstances regarding this violation are as follows:

114. Respondent committed violations of Business and Professions Code sections 2234, subdivisions (b), (c) and (d), 2240, 2216.2 and 2266 as more specifically set forth above in paragraphs 17 through 57, 69 through 90, 93 to 96, 98 through 104 and 106.

DISCIPLINARY CONSIDERATIONS

115. To determine the degree of discipline, if any, to be imposed on respondent, respondent's prior discipline should be considered. The circumstances are as follows:

116. On June 25, 2001, Third Amended Accusation No. 06-96-69949, was filed in the matter entitled, *In the Matter of the Accusation Against Lawrence Saks, M.D.* Multiple charges were alleged in the Third Amended Accusation against respondent for gross negligence, repeated negligent acts, incompetence, false insurance claims, preparation of statements as false and fraudulent claims, making of false statements in a document related to the practice of medicine, alteration of records, and failure to maintain adequate records, in violation of Business and Professions Code, in and during his care and treatment of multiple patients. On April 30, 2003, in a Stipulated Settlement and Disciplinary Order, Respondent admitted to the truth of each and every charge and allegation contained in the Accusation. On August 12, 2003, the Board adopted the Stipulated Settlement and Disciplinary Order, with an effective date of September 11, 2003. Respondent's Physician's and Surgeon's Certificate was revoked. The revocation was stayed and Respondent was placed on probation for seven (7) years with terms and conditions. Respondent's probation term began on September 11, 2003, and is set to expire on or about September 11, 2010.

117. On April 23, 1991, an Accusation as filed against Respondent in the matter entitled, *In the Matter of the Accusation Against Lawrence Saks, M.D.*, Case Number 06-1990-5275. The Accusation was based on his conviction for income tax evasion on September 24, 1990. On November 22, 1991, pursuant to a Stipulated Settlement and Disciplinary Order, Respondent was placed on probation for a period of five (5) years under various terms and conditions. On February 24, 1993, respondent petitioned for early termination of his probation. On December 6, 1994, his petition was granted.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 36859, issued to respondent, Lawrence Saks, M.D.

2. Revoking, suspending or denying approval of respondent Lawrence Saks, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Respondent Lawrence Saks, M.D., if placed on probation, to pay the Division of Medical Quality the costs of probation monitoring,;

4. Taking such other and further action as deemed necessary and proper.

DATED: August 1, 2006

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2005500912